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## CLINICAL LECTURE.

**HYDROCEPHALUS.—CEPHALHEMATOMA.—PRESSURE OEDEMA IN PREGNANCY.—OCCIPITO-POSTERIOR POSITION; INSTRUMENTAL DELIVERY.<sup>1</sup>**

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### Hydrocephalus.

*Gentlemen:* This morning I wish to call your attention to this child, which presents an interesting condition. It is nine months of age, and was delivered after a normal labor, an easy parturition. It was breast-fed until it was six months old; and this was supplemented by the use of good cow's milk. It appeared to be a remarkably healthy child until two months ago, at which time the mother noticed that its head was increasing in size. The question which immediately arises is: What is the pathological condition which is going on in this child's head? Is this a case of hydrocephalus or of rickets? We are not always able thus early to tell whether one or both of these conditions are present. There is one point in this case which appears to indicate a rachitic condition, and that is the peculiar narrowing of the head at the temporal region. While we look at the veins of the head, we notice a distinct enlargement all over the head. There is also a bulging of the vertex, together with an enlargement of the skull above it; which, however, is not excessive. There are times, as in this instance, when a positive diagnosis between rickets and hydrocephalus cannot be made. The best way by which we

could determine this point would be to take the measurements of the head from time to time, and note the progressive rate of increase in size; these measurements should be made in the circumference just back of the ears, and also in the antero-posterior diameter.

There is another point of distinction: in marked hydrocephalus there is always a peculiar appearance of the eyes, when, owing to the bulging of the forehead and the displacement of the orbital walls, the position of the eye is altered, and the sclera shows more extensively than it should, giving a staring appearance to the eye. This appearance is not yet present in this case. By examining this child's skeleton at various points, we can ascertain if there are any other signs of rickets here; as the child cries, the blue veins to which I have called your attention show quite distinctly. Examining the breast, we see an eruption upon it which is commonly seen on young children, especially if the weather is warm and the child be warmly clothed. The articulations of the ribs are normal, and there is no enlargement of the joints at any point. This, therefore, goes to confirm our diagnosis of an early stage of hydrocephalus.

Hydrocephalus is commonly said to be of two kinds: the internal and the external. By hydrocephalus we mean an accumulation of fluid within the cranium. This may be between the dura and the skull—external hydrocephalus—but is generally between the membranes and the brain substance—internal hydrocephalus. The external variety probably never exists as such, but is always secondary to some other condition. Internal hydrocephalus is due to a congenital malformation of some portion of the brain substance, or it may be due to tubercular meningitis, or to a tubercular tumor within the brain. The head at times may increase in size at the rate of three-fourths of an inch per day.

<sup>1</sup> Delivered at the Philadelphia Hospital.

The symptoms of this condition are an increase in the size of the head and a gradual decrease in the intellect. Such children generally become idiotic, and as a rule die in convulsions, which are produced by the pressure of the fluid upon the fourth ventricle. During the last winter I showed you the head of a hydrocephalic child which beautifully exhibited the pathology of this condition. There were one or two quarts of fluid in the brain, the ventricles were large cysts and the brain substance and membranes were flattened out as thin as a sheet of heavy paper.

Now as to the treatment of this condition. Ordinarily these children do not live to be more than two or three years of age; there are cases recorded, however, where they have reached the age of six, eight or ten years, the disease having been arrested in its progress. As soon as the disease is discovered there is no objection to removing the fluid. An aspirating needle, rendered aseptic, should be introduced into one of the lateral angles of the anterior fontanelle and the fluid may be thus evacuated. Following this we may strap the head with adhesive plaster, observing, however, great caution, because the scalp is often so tender that the straps, if improperly applied, may give rise to soreness and ulceration, and the child's condition be aggravated. The use of an elastic bandage is much preferable to the use of adhesive plaster. If, however, the plaster be used, it should be removed every two or three days and the parts powdered with a drying and antiseptic powder, such as boric acid. Iodide of potassium, counter-irritation to the back of the head and neck by blisters, and setons have been tried, but with poor success. I am not aware that salines in small doses have been used in these cases, but possibly this would be a rational method of treatment.

There may be a condition of intra-uterine rickets with malformation of the skull and pressure upon the brain, resulting in hydrocephalus. In extreme cases the weight of the head becomes so disproportionate to the size of the body that the head cannot be supported by the child. Death usually soon ensues in a condition of coma with convulsions from pressure upon the brain substance surrounding the fourth ventricle. Syphilis may complicate hydrocephalus, and occasionally brain tumor may produce it.

A few words as to the future treatment of hydrocephalus in these days of brain sur-

gery. It is perfectly possible to drain the ventricles of the adult brain. About eight years ago a policeman was assaulted by roughs who injured his head so severely that intra-ventricular suppuration ensued; he was operated upon and the pus withdrawn successfully. Whether or not suppuration recurred and he subsequently died I do not know. Now, if we can do this in the adult head, we have no reason to doubt that we can do the same in a child.

### Cephalhematoma.

The next case is one also of head trouble. The history is that the child was admitted on Monday of this week three days old. After birth a tumor was noticed on its head. The mother is anemic and with a tendency to post-partum hemorrhage. Examining the head I find here a tumor over the left occipito-parietal juncture, and as I tap it with my finger, you will observe a gentle fluctuation. It seems to be a cephalhematoma; but we must first be sure that it is not a meningocele. By gentle palpation I can recognize the skull under the tumor; the tumor is, therefore, outside of the bony substance of the head. It may be a simple scalp tumor, but the probabilities are that it is the result of an injury to the head causing an effusion of blood beneath the scalp, with an injury of the membrane over the skull. This is not a very rare occurrence. Last winter I showed you a case of double hematoma, which is rare. The diagnosis of this condition is the main point of interest. Were it a meningocele, it would show the pulsation of the brain substance; this, however, is not present.

As regards treatment: compression and nothing else is required. Do not evacuate such tumors, but make gentle pressure on the part. If the temperature should rise and symptoms of suppuration ensue, then open in two places, wash out with a dilute antiseptic fluid and make compression. Ordinarily, however, the tumor will be absorbed in the course of two weeks.

### Pressure CEdema in Pregnancy.

The next case is that of a woman almost at term who presents some interesting symptoms. She is a healthy, strong-looking woman, with a large, well-developed skeleton. When she is on her feet she is exceedingly annoyed by a swelling of her lower extremities. This differs from the usual

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cases of cedema met with in practice, in the fact that one leg swells more than the other: it is an unilateral cedema. The color of the patient is that of a fair degree of health. Her family history is negative so far as any disease is concerned; her maternal grandparents both died of dropsy. In November, 1889, her right foot began to swell; and this continued, with no other trouble, until two weeks ago, when the left foot began to swell also. At the same time the general circulation became disturbed, as evinced by palpitation of the heart and a soft systolic murmur heard over the second costal cartilage on the right side. The specific gravity of her urine ranges from 1.020 to 1.030. In the last twenty-four hours she has passed eighty ounces of urine and in the previous twenty-four hours she passed fifty ounces. This array of symptoms gives us an interesting subject for study.

The position of the uterus during the last weeks of pregnancy is usually that of right lateral obliquity. If we bear this fact in mind, we may arrive at a rational conclusion as to the cause of the swelling of this woman's limbs. Her right leg, which was intensely swollen, has almost entirely recovered under rest. Therefore, the dropsy was a transient condition, due not to organic disease, but to some mechanical interference with the circulation. Examining the abdomen as the patient lies in the recumbent position, we see the usual appearance of the abdomen of advanced pregnancy. The fundus of the uterus is slightly above the umbilicus. The back of the child is to the right, the smaller fetal parts to the left side. The appearance of the abdomen is that of a large tumor upon the right side. The so-called obliquity of the uterus is not so apparent as when the woman is in the semi-recumbent position, but the preponderance of weight is distinctly upon the right side. The increase in the size of the liver in the last part of pregnancy is a distinct factor in influencing the fetus to take its position on the left side of the abdomen, and also in influencing the obliquity of the uterus. It takes up some of the room which the uterus tries to fill, and thus favors the turning of the fetus into the left occipito-anterior position. In this case, however, matters are reversed, the liver is enlarged and the child to the right. The uterus always inclines to one side or the other; and here we have an excessive right lateral obliquity of that organ, probably due to the

roominess of the pelvis. As a result of this change, there is an increased pressure upon the venous trunks on this side. This can be avoided by maintaining the recumbent position.

Now, as to the condition of the heart in this case. There is no symptom in the case which would lead us to ascribe any importance to the systolic murmur which is heard. The kidneys are doing their work; and continued rest in the recumbent position, together with proper attention to the condition of the bowels, will be all that will be necessary for the patient's relief. There are other things to be said about the case which are of equal and possibly of greater interest. When labor comes on, we may have some very interesting complications. If the membranes should rupture while the patient was in a standing or semi-recumbent position, a lateral presentation may occur, caused by the rapid discharge of the amniotic fluid. Or, again, we may have quite a precipitate labor; or we might have a face presentation. Occasionally in a breech presentation, in such a case as this, we might have the complication of the arms extended along the head, or the occurrence of the extension of the head at delivery.

#### Occipito-Posterior Position.

I wish to speak now of a case which recently occurred in the maternity ward. The patient was a primipara, 26 years old. On her admission into the ward the os was found to be dilated to the size of a quarter of a dollar. It was a difficult matter to reach the os, which was directed far back towards the sacrum. On abdominal palpation the back of the fetus could not be distinctly outlined; but the heart could be heard on the right side. The pains, which were weak, were made more forcible by the administration of sixteen grains of quinine; the membranes were punctured, and the head descended to the pelvic floor. Up to this time the diagnosis of the position had not been made. I had examined the woman, and could only make out an occipital presentation. I could feel a suture—probably the sagittal, which was not in its normal position. At this point the diagnosis of a right occipito-posterior position was made. Efforts were made to cause rotation anteriorly by the introduction of the hand, with final success, although it was not known at what precise moment rotation occurred. Even then the head could not be delivered until



the forceps was applied. The cause of the dystochia was that the head presented by the occiput instead of the vertex. The perineum was torn to the bowel; and three sets of stitches—rectal, vaginal and perineal—were inserted.

The case is of interest as being one of occipito-posterior position. If we examine the records of maternity hospitals, we shall find that there are more of these than we would expect. I have collected 170 or 180 cases of occipito-posterior position occurring in over forty years in this hospital. The points of interest in this case were first the difficulty in diagnosis. In such a case the only thing to do was to watch and wait, after the administration of a tonic such as quinine. When rotation did not seem to be possible, then the only instrument advisable was used, and that was the aseptic hand. In such cases we should administer chloroform, introduce our hand, and make our diagnosis. In an occipito-posterior position, either the trunk is situated abnormally in the pelvis, or it is situated normally, and—as occurred here—the head rotates from one-quarter to one-half of a circle. In this case the forceps was indicated for the safety of both mother and child. The laceration which occurred was that which you will get in most cases of primiparæ where such an abnormality exists. The dilating and softening influence of the head on the perineum is lacking, and a tear will result.

## COMMUNICATIONS.

### BLEEDING FOR PNEUMONIA.

LETTERS BY DR. W. STUMP FORWOOD,  
DARLINGTON, MD.,  
AND  
DR. JOHN R. QUINAN,  
BALTIMORE, MD.

[The following letters are a valuable contribution to the literature of the subject of the treatment of pneumonia which was discussed with so much force by Dr. Hiram Corson, in his series of papers in the MEDICAL AND SURGICAL REPORTER, March 22 and 29, April 19, May 17.]

DR. FORWOOD writes: Having read with deep interest, and full concurrence, the four papers recently published in the REPORTER on pneumonia and its treatment, from the pen of the distinguished professional vet-

eran, Dr. Hiram Corson, of Montgomery Co., Pa., I felt induced to send a copy of the same to my friend, Dr. John R. Quinan, of Baltimore, knowing him to be a physician of wide experience in the treatment of disease, and one who had been accustomed to the free use of the lancet in such cases as in his judgment it appeared to require it. At the same time I requested him to make such remarks upon Dr. Corson's papers as were in full accordance with his best judgment; and in such a form as might be presented, if desired, to the readers of the MEDICAL AND SURGICAL REPORTER.

Dr. Quinan's views on the subject, more pointed and confirmatory of Dr. Corson's conception of the pathology and treatment of the disease than I expected, are herewith appended, in a letter received from him by to-day's mail; and, with his permission, his remarks are now offered, with this explanatory preface, for publication in the columns of your much-esteemed journal.

DR. QUINAN writes: Allow me to thank you for the very great pleasure you have afforded me in reading Dr. Hiram Corson's article on pneumonia and its treatment. The author is, I am told, a distinguished practitioner of Montgomery Co., Pa., and a veteran of 80 years—but it is evident from the vigor and closeness of his reasoning that his mental vision "is not dim nor its natural force abated." As I am on the eve of meeting a consultation out of town, I am too hurried to do more than make a few cursory remarks that the paper suggests. To do full justice would require more time than I can now command.

Dr. Corson's position is: 1, That pneumonia is a local inflammation, and not, as asserted by Dr. E. F. Wells, and others, a "pneumonic fever," *i. e.*, "a general disease with a local manifestation in the lungs;" 2, That, for the acute, sthenic form of this disease, attended with profound congestion and speedy inflammation, blood-letting promptly and judiciously used, in the first or second stages, offers the best and most efficient remedy. He fortifies both points by a large array of eminent authorities strengthened by his own extended experience; and if it could give the slightest weight to his argument, I might add my own unhesitating endorsement of the soundness of his views and conclusions, derived as mine are from an acquaintance with the disease in question during forty-six years of active practice.

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But let us examine his views in more detail. It is, he asserts, a local disease, differing in nothing but its seat and gravity from other phlegmasiæ. It sets in suddenly with a chill, after some undue exposure, and exhibits no prodromata, as do general or idiopathic fevers. It is often confined to one lung, and as frequently to one lobe of that lung; and further, one attack does not procure immunity from another—as we should certainly expect if it were a specific fever. But, say those opposed to its being considered a local disease, it runs a definite and limited course, and hence we must conclude that it is a specific, general fever. Granting the fact that pneumonia does run a definite and limited course, marked by successive stages of congestion, exudation, resolution, or consolidation and suppuration—in what does it differ in this respect from the course of inflammation in any other vascular organ, such as the liver, brain, kidney or spleen?

Their reasoning is false by proving too much, as it would obliterate the whole catalogue of phlegmasiæ from our nosology. In the microbe mania that affects the pathology of the present day it is a fashionable fad to ascribe every disease to a parasitic source, and since Friedländer discovered (as he claims) a pneumococcus in this disease, it was at once assumed that the disease had this specific origin. But the necessary proof is wanting to show that the pneumococcus has any causal relation to the disease, and I think we may safely dismiss this point by referring Dr. Wells and those who maintain that pneumonia is a general fever to the report of "The English Collective Investigation Committee on Pneumonia," based on a study of 350 cases, which appeared in the *British Medical Journal*, Dec. 1, 1883. It says, "We think the evidence before us is insufficient to support the doctrine that pneumonia is a specific fever, whose chief local manifestation is in the lung. Like all respiratory diseases we find it prevailing in certain states of the weather. The great regulator of its frequency is season. It confers no protection on the individual, but rather increased liability to future attacks—has no direct association with any specific disease; epidemic pneumonia is in part explained by atmospheric conditions and in part by other agencies prejudicial to health." Remember these inferences were drawn from answers to inquiries extended over the whole civilized globe, and of course include every

possible aspect of the disease among all ages, colors, sexes and conditions.

Admitting then that we have in pneumonia a local inflammation to deal with, how can we best combat it? Since the dawn of historic medicine, there has been but one reply: venesection, fully, promptly and judiciously used. But of late men of science so-called have elaborated the theory that the tendency of the disease, in the majority of cases, is towards recovery, and therefore that it is best left alone! Admitting, for the sake of argument, that some patients do struggle through the attack unaided by our art, how is the practical physician to decide that the case before him is to prove one of the fortunate few who recover, or one of the unfortunate many who succumb to the disease? These expectants do not tell us; and to follow their teaching is simply to reduce the rôle of the medical attendant to a "meditation on death." Another class advises the use of stimulants (oil to extinguish fire!), as if the heart was not sufficiently over-excited already! Still another class would use digitalis, a heart tonic, leaving out of consideration the fact that the *vis a tergo* is too great already for the safety of the lung; while a fourth class would have us employ veratria, aconite and other sedatives, which are often so uncertain and slow in their action as to either kill the patient by their violence or let him die by their delay in taking effect.

The ideal therapeutic agent needed in acute croupous pneumonia is one that will lessen the *vis a tergo*, and at the same time remove the blood on the venous side, to enable the vessels to empty themselves and excite a certain amount of *vis a fronte* which results not only in a temporary relief of the arterial stasis but in an increased rapidity of the current and a lessened force of circulation. Both these results are secured by blood-letting and by blood-letting alone. Those who are sceptical about this explanation would do well to read the convincing experiments of Gensmer on the antiphlogestic effect of blood-letting in the *Centralblatt f. die Med. Wissenschaften*, April 1, 1882. He is dealing, it is true, with local, but it is equally applicable to general depletion, as the essential pathological conditions are the same.

But whatever theory we may adopt as to the *modus operandi* of this remedy, the test of its efficacy is in the experience of the bed-side. Trial there is the *experimentum*

*crucis* of all our remedies; the effect of their use on the sick decides their value. Whether or not science can satisfactorily explain their mode of action is a secondary consideration. Self-evident as it may seem, it is too often forgotten that our art is founded on experience alone. If science can arrange the facts and deduce from them some universal law for our guidance, well and good; but she cannot supply the facts; these are to be derived from observation and experience; and often the art of medicine and common sense flatly contradict the assumptions of what is advanced as the science of medicine and which is solemnly and dogmatically announced from the professional chair by men who have derived their knowledge of remedies in a physiological laboratory from experiments on frogs—or elaborated them from their fancy.

This applies with peculiar force to the use of blood-letting in pneumonia. I venture to say no one who ever tried it (and none other can decide) in the congestive stage of this grave disease, and witnessed its benefit, could be induced to resort to any other remedy. My own experience confirms all that Dr. Corson claims for it. I use it in every case of sthenic pneumonia in its early stages, and always with prompt relief, sometimes cutting short the attack *in toto*. My case-book shows that, under this treatment, the mortality was one in seventeen cases. On one occasion, while riding, I was stopped to see a colored man who had been seized with a violent chill in the field, where he was still lying. On reaching him, I found a young, athletic man, in the first, or congestive stage of pneumonia. Knowing the value of time, I at once tied his arm and bled him until the pulse softened and the dyspnoea ceased. He was then carried to his house, and on visiting him that evening I found him completely convalescent; and in a few days he was at work in the field. Of course, I was not always fortunate enough to catch the disease in the forming stage, as in this case, and to *jugulate* it as I did; but I mention it to show what a timely bleeding will effect. I was in the habit of instituting one full bleeding as early as possible, following it up with tartar emetic in minute doses, together with calomel and opium, the application of poultices to the chest, and, in the latter stages, blisters, with all the nourishment of easy digestion that the patient would bear. In the latter stages I employed muriate of am-

monia, combined with tincture of opium and the addition of minute doses of tartar emetic, the amount of the latter proportioned to the febrile movement.

Dr. Corson adduces the authority of men of the largest clinical experience in favor of the lancet in this disease, men who were not to be misled into trifling with the life of the patient by the *laissez faire* plan, or by any other agent but the lancet. Dr. John L. Atlee, in his able address before the American Medical Association, June 3, 1883, said: "I feel well assured that the almost total disuse of the lancet has cost many valuable lives. From a very large experience in its use, I am satisfied—fully satisfied—that if we depended more on the early use of the lancet in the congestive and inflammatory states of many diseases, our practice would be more successful than it now is." Again, the late Dr. Richard McSherry, a man of very extensive acquaintance with disease, in military, naval and private practice, and one thoroughly fitted to estimate the relative value of remedies in this and all other diseases, says, in an article which appeared in the *Medical News*, September 3, 1883: "Is blood-letting a proper remedy in acute inflammation? Aye and nay come down upon us from remote ages. In the face of an appalling opposition, *I believe blood-letting to be the most potent if not the safest of antiphlogistics.*" (Italics mine.) Like all potent remedies, making prompt and decided impressions, it is, when in fashion, liable to great abuse; but, *abusus non tollit usum*; and blood-letting is a remedy too much neglected. It happened that among our pupils were two very intelligent medical cadets then serving in army hospitals near the city. When examining these young men for degrees, I took occasion to examine on pneumonia, and questioned both as to what they had read and what they had seen. I will call them Mr. M. and Mr. K. Mr. M. had seen a great many cases of pneumonia. When I asked him what was the treatment, he replied: "Generally stimulating." When I asked the result, he said the mortality was large. When I asked further: "How large? Fifty per cent. more or less, of the patients?" the answer was: "Much more." My expression must have been one of surprise; for the candidate immediately added: "Professor, a great many of the cases came into the hospital far advanced in the disease and some actually moribund." I then said that stimulation

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was probably the best your surgeons could do for them; but, had any of these men any marks about them to show general or local abstraction of blood? The gentleman replied: "They had not."

When Mr. K. came up I took him over the same ground. He had seen a great many cases of pneumonia in hospitals, about one-half of which proved fatal. The treatment was stimulating. Upon inquiring if any of the patients had been bled before or after coming under his observation, he said: "No, I never saw a man bled in my life." When Mr. K. (now Dr. J. H. Kidder, U. S. N.), after passing a brilliant examination before the Navy Board, called to pay me a friendly visit, I referred to his hospital experience and asked how the surgeons explained the large mortality in pneumonia. His answer was that they supposed the lost cases had not been sufficiently stimulated. "And I remember," said I, "my young friend, when it would have been said: The man died *because not sufficiently depleted in the early stages.*"

I mentioned these facts, some time after their occurrence, to a practitioner in this city who had been employed in one of the hospitals in question. The gentleman said that he remembered distinctly two cases of recovery, in both of which the patients had been freely cupped! Are not such facts worthy of note as offsets to the statements of Bennett and Todd that when pneumonia proved fatal, it was rather due to the treatment (by blood-letting) than to the disease? Drs. Bennett and Todd were both very able men, but they were as liable to mistakes as the rest of us.

But I have made this letter too long, I fear, for your patience, and must close with again assuring you that I believe Dr. Corson's views in regard to this disease and its treatment are in full accordance with common sense, sound theory and well-attested experience, and I endorse them to the letter.

**NAPHTHALIN MAY AFFECT THE EYES** in an extraordinary manner, as demonstrated by Dr. Kolinski, in Von Græfe's *Archive*, through its property of deleteriously affecting the nutritive property of blood. The eye being a highly vascular organ, its structure readily undergoes degeneration. The effects of the administration of naphthalin are ecchymosis, white patches in the retina, cloudiness in the lens and crystals in the vitreous humor.

## ETIOLOGY OF CHOLERA INFANTUM.

BY GEO. TROUP MAXWELL, M. D.,  
JACKSONVILLE, FLA.

In an Editorial in the *MEDICAL AND SURGICAL REPORTER*, July 12, 1890, on the "Etiology of Cholera Infantum," this sentence occurs: "Passing by such predisposing causes as age, constitutional feebleness, bad hygienic surroundings, impure air and water, dentition, etc., there remain two causative factors in the production of cholera infantum which deserve careful study, namely, high temperature and the food supply." The baneful effect of high temperature is inferred by the writer, because certain authors of celebrity, named, have "shown that, taking the average of a large number of years, the mortality from diarrhoea increases rapidly from May to July, and then steadily decreases." And "the fact that, according to statistics collected by Holt, of nineteen hundred and forty-three fatal cases, only sixty-one, or about three per cent., had the breast exclusively, is conclusive evidence that high temperature, in itself, is not the most important of the two causes under discussion, and indicate that the heat is harmful chiefly by bringing about certain changes in the food supply of hand-fed children."

As I seriously doubt the correctness of the assumption that there is the relation of cause and effect between high temperature and the food supply, and cholera infantum, I would like to have an opportunity to give some reasons for dissenting from the conclusions which seem to have so much to support them.

It is admitted that "after July the mortality from cholera infantum steadily decreases." Is it meant to imply—what, I submit, is the logical inference from the statement—that the number of deaths from cholera infantum steadily decreases after July, because the temperature rapidly diminishes and the food supply improves in quality?

I beg to be excused for quoting from a paper on this subject which I had the honor to read before the Section on Public and International Hygiene of the Ninth International Congress, held at Washington, September, 1887, as follows: "Dr. Davis (of Chicago) has shown by mortuary statistics, and by his personal investigations,



that July is the especial delinquent—more than three-fourths of the cases beginning in that month. This is not, so to speak, accident. It is the rule; and there must be reason for it. If continuous high heat, through successive days and nights, associated with stagnant air, is indeed the *causa causans* of cholera infantum, it must appear that such meteorological conditions are distinguishing characteristics of that month. Is that the case? Let us see. There were, at Chicago, in July, 1886, 13 days in which the temperature reached 80° and above; in August, there were 14. In July there were two groups of three successive days in which the temperature reached 80° and above, one being of five days' duration; in August, there were three similar groups of successive hot days—one continuing four and another five days. The longest continuance of hot days, with a break of a single day, was, in July, six, the mercury descending one day to 76.3°; in August, ten, the mercury falling one day to 79°. The sum of the thirteen hottest days in July, is 1,114.2°; in August, the sum of the fourteen hottest days is 1,198.4°—a difference of 84°. The mean daily range of temperature was, in July, 13.9°; in August, 12.2°. The least daily range of temperature was, in July, 5.6°; in August 4.2°. August was, therefore, the hotter month, with a greater number of, and longer lasting groups of successive hot days; with lower mean and daily range of temperature, and it followed June and July with their intense heat. Besides, the records show that there was more movement of wind in July than in August; or, in other words, the air was more stagnant in the latter than in the former month, there having been 5,472 miles of movement in July and 5,439 in August. With higher and longer continuance of heat and a calmer air in August than in July, the former ought, according to the hypothesis of Dr. Davis (and of the Editor of the REPORTER) to furnish a larger mortality list; but, on the contrary, the statistics show 285 deaths from cholera infantum, in July, and 201 in August—a difference of 84, which disparity would be greatly increased if three-fourths of the cases that died in August were charged to July, where they undoubtedly had their beginning. It is logically impossible to explain the high annual mortality from cholera infantum in July and the great and sudden decrease in the number of deaths in August, by the hypothesis of Dr. Davis (and the Editor of

the REPORTER)—that is, upon the supposition that high heat, stagnant air and improper food are the principal causes; for these are as marked characteristics of August as of July if they are not more decided."

Besides, what becomes of the theory of the Editorial when the experiences of Northern and Eastern cities are contrasted with those of the Pacific and the Gulf States? In a paper read by Dr. N. S. Davis at the meeting of the American Medical Association at Detroit, in 1882, he said: "There is no evidence within our knowledge which shows that the milk distributed in San Francisco and New Orleans is any purer or of better quality than in Boston or Chicago. Neither are nursing mothers any more free from mental and physical infirmities, nor the sanitary condition of the dwellings, sewers, etc., more perfect in the former than in the two last-named cities. Yet an examination of the mortality statistics shows a ratio of about five deaths from cholera infantum, annually, for every 10,000 inhabitants in San Francisco and seven in New Orleans; while Boston gives 25 and Chicago 30 deaths from the same cause, for every 10,000 inhabitants." Surely some other cause, or causes, than "high temperature and food supply" must be found, to explain this striking contrast!

Florida, the most southern State in the Union, is comparatively exempt from cholera infantum. Dr. Hicks, at the time the Health Officer of Orlando, in South Florida, in reply to my inquiry, wrote: "Cholera infantum is almost unknown here." The same is true of almost every city and town in the State. Will it be contended that this remarkable exemption from cholera infantum in Florida and other Gulf States is due to lower elevation and shorter duration of heat, and better quality of food, with improved hygienic conditions? Again, quoting myself: "It thus appears that cholera infantum has its chief home in certain climatic regions; and that, within the territorial area which furnishes the conditions for the production of its cause, it prevails among the rich as well as the poor, in palatial residences as well as in crowded tenements and filthy cabins, in towns, villages, hamlets and isolated farm-houses as well as in compactly built insanitary cities. More; in the territorial area within which cholera infantum prevails, neither topographical nor other physical features of localities exert appreciable restraining influence; for its deadly

work is done on plateaus has yet significant terrible sequel and the South yellow and etc., is a cause. I results from or from a toxin. which produces else. cal science the specific exists and tions of the summer Middle S finds its tropical cholera is germ of in the N Union. nous with that their nate in remarkable than for or fruits easy to find kingdom origin of made to onstratic chemico of cholera supplant cillus of

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work is done at the seashore, on elevated plateaus and upon mountains. The cause has yet to be discovered; but the patent, significant fact remains, that, whereas it is a terrible scourge at the North, it is an infrequent and comparatively trifling affection at the South. . . . Cholera infantum, like yellow and typhoid fevers, Asiatic cholera, etc., is a specific disease, and has a special cause. It is not a gastro-enteritis, such as results from indigestible or fermented food, or from acrid poisons, like arsenic and tyrotoxin. It is the effect of a specific poison which produces cholera infantum and nothing else. In the present status of etiological science it is a reasonable assumption that the special cause is a micro-organism, which exists and propagates under suitable conditions of climate such as are presented during the summer, in the Northern, Eastern and Middle States. As the germ of yellow fever finds its favorite home in tropical and semi-tropical America, and the germ of Asiatic cholera its appropriate *nidus* in India, so the germ of cholera infantum makes its habitat in the Northern and Eastern States of our Union. That their appearance is synchronous with the approach of the 'heated term;' that their numbers and power should culminate in July, or midsummer, is not more remarkable or inconsistent with natural laws than for flowers to have their time to bloom or fruits theirs to mature; and it would be easy to find analogies throughout the animal kingdom. As the theories of the chemical origin of the malarial poison have been made to give place to the microscopic demonstration of the malarial bacillus, so the chemico-physical hypotheses of the etiology of cholera infantum must, in their turn, be supplanted by the soon-to-be-discovered bacillus of cholera infantum."

#### CHILD-BIRTH AT TWELVE YEARS OF AGE.

BY E. B. WALES, M. D.,  
COLD SPRING, N. J.

On January 1, 1890, Mrs. R., colored, called to see me in reference to her daughter, who was suffering, as she supposed, from suppressed menses. On inquiry I learned that she had last been unwell in September; that her age was twelve years, and that she first menstruated some time before she was seven years old. As this is very young in-

deed for a girl to mature, I asked the mother if she was certain as to the girl's age, and she assured me that she was. I told the mother that she must not be alarmed about her daughter and that in a few days I would call to see her.

Some four or five days later I called at the house and found the girl lying on the lounge with her body and face well covered with some article of clothing. The mother said she complained of feeling weak and easily fatigued, and of having a little sickness of the stomach. I asked the child to get up and to come over to where I was sitting. She did so; but very reluctantly. She apparently did not feel very pleasant towards me, and I could not, in any way that I could devise, attract her attention or get her to fasten her eyes on me. On examination I found the pulse natural, the tongue clean and the respiration normal. The girl was pale and somewhat emaciated. I questioned her closely, but failed to get any answers, and I soon discovered that I had a patient who, though young, was as sharp and artful as one would wish to encounter. As she stood in front of me I noticed her becoming very nervous and faint, and I requested her to lie down. The thought occurred to me then that the girl was pregnant. Her very behavior spoke it. But I asked myself, Can such a thing be? Having become pretty well convinced, however, that this diagnosis was correct, I remarked to the mother that I would not prescribe anything for the present, but would call in after a little; and suggested that she should send for me if she needed me. I advised her to say nothing about the case to any one, for fear the wise women of the neighborhood would say that the girl was in the family way. This idea the mother thought preposterous, saying her daughter was a mere child, and that she feared she was going into a decline. I assured her she need have no fear of this and took my leave. In March, as I was passing the house, I called to see the girl and found her at work and in good spirits. She said she was feeling much better. The moment I saw the child, I was convinced she was pregnant; and, calling her mother to one side, I informed her of the fact. The child denied it positively up to the time of her labor.

On July 15, I was summoned hastily, at about 6 A. M., to the home of the girl. I arrived an hour later, and found her in the last stages of labor. The mother said she

had been in labor about six hours. She was suffering with bearing-down pains. I made a digital examination and found the os uteri nearly dilated, the membranes unruptured, the pains regular and not very severe, the pelvis spacious, the patient quiet and cheerful. She was soon seized with a severe pain, and a spontaneous rupture of the membranes immediately ensued. The pains came on, and recurred at short intervals, and in a short time the girl was delivered of a fine, healthy boy, weighing *eleven pounds*. She was possessed of great self-control and there were no moans or agitation during the labor. The labor was easy and natural, and the placenta was expelled without interference about twenty minutes after the child was born. The flow was rather copious, yet not enough to cause any alarming depression. The presentation was vertex, in the first position. The mother and child are now (July 21) both doing well; she nurses her babe and has a great flow of milk. She is of medium size, rather tall and slender, but well developed. Her age was twelve years on March 8, 1890.

#### SYNOPSIS OF THE PENNSYLVANIA REGISTRATION ACT OF 1881.

BY R. L. SIBBET, M. D.,  
CARLISLE, PA.

[For the benefit of the readers of the *REPORTER*, Dr. Sibbet has prepared a brief synopsis of the law for the registration of medical practitioners in Pennsylvania, which will enable them to understand more fully the questions connected with this subject recently discussed in Editorials in this journal.]

We need not concern ourselves at present about the indirectness or obliquity of this Act of Assembly—whether this feature of it was accidental or intentional. It is sufficient to state, as Judge Woodward has done, “that it is in all respects a valid and constitutional statute.” Nevertheless it may be useful to present the following synopsis for the consideration of the profession.

Sec. 1 relates chiefly to the work of the Prothonotary. “His duty is merely clerical.” “He can dispense with nothing which the law requires.” He cannot substitute anything. (See Judge Woodward.)

Sec. 2 fixes the standard of qualifications of the practitioner of medicine. He must

have the degree of Doctor of Medicine. Of course he cannot obtain it fraudulently. He must have a residence. He may also be a sojourner. (See Judge McPherson.) In either case he must present his diploma to the Prothonotary, as well as a true copy of it, including the endorsements on it, to be filed. He must give his full name, his place of nativity, his residence, the name of the institution which conferred upon him his degree, and he must do all this under oath or affirmation.

Sec. 3 provides for practitioners whose diploma has been destroyed or is lost.

Sec. 4 makes the medical faculties of the Commonwealth of Pennsylvania the sole judges of the qualifications of foreigners or those who are graduates of medical schools outside of the State. The faculty may require an examination, but the dean must endorse the diploma before registration. A certificate on a slip of paper is not an endorsement. (See Judge Elwell on this section.)

Sec. 5 provides for non-graduate practitioners. They are allowed to register provided they have been in continuous practice in Pennsylvania since 1871. (See Judge Woodward.) Men who manufacture liniments and sell them are not practitioners and cannot register. The people do not call them in to prescribe. The court must decide the question.

Sec. 6 provides for compensation for the Prothonotary. It is fraudulent registration unless it is paid for.

Sec. 7 defines a misdemeanor. The presentation of a diploma “obtained fraudulently” is a misdemeanor. A diploma must be obtained in an honest and honorable way. A chartered institution may issue a fraudulent diploma. The faculties of our medical schools and the prothonotaries of our courts were the first to disregard this part of the law. The registration of a foreign diploma without an endorsement is a fraudulent procedure and a misdemeanor.

Sec. 8 provides for practitioners residing in other States. They may practice in Pennsylvania, but they cannot do so without registration if they open an office. In this case the practitioner becomes a sojourner. A resident of one county may sojourn in another county part of the year, but he must register in both. He cannot, however, sojourn at the same time in two or three counties. He cannot become an itinerant under the law. (See Judge McPherson.)



## FOREIGN CORRESPONDENCE.

## LONDON LETTER.

*Foreign Correspondents.—Lengthening the Medical Course.—Lectures in Medical Schools.—Dietetic Treatment of Gout.*

One of the American medical journals has lately indulged in some caustic comments on the value of the English letter. After reading those remarks the writer at once decided to throw up his post as London correspondent to your journal; a hasty resolution, however, which further consideration has somewhat shaken. One of the chief objections urged against the special epistle seems to be that its matter is not always original. Does any one need to be reminded at this stage of the world's progress that journalists are the greatest borrowers on the face of the earth? Nowadays, with rapid and far-reaching communication, the fame of anything new is noised abroad to the four quarters of the globe in less time than that in which Puck undertook to place a girdle round the earth. Matter may be stale; yet the method of retailing it may be fresh, crisp, original and instructive. The axiom may be laid down with some degree of confidence that there are few pleasanter ways of drawing in stores of information than from the gossip of a well-written letter. The reader is thereby furnished with the easily-digestible extracts of a hundred journals to learned societies, spiced with the correspondent's own individuality. To be successful, a journal can hardly supply too varied a bill-of-fare. Besides—although the exact rate of payment for these contributions shall be concealed with cuneiform secrecy—it will be no great breach of confidence to hint that remuneration is not on so magnificent a scale as to warrant a man of average abilities spending more than, let us say, three or four days in composing one of them. The paragraphist remarks, truly enough, that the late Dr. Milner Fothergill was the first to draw attention to the London letter in American medical literature. The writer thus alluded to was possessed of great literary abilities, and had the rare gift, amongst others, of throwing a halo of interest around any topic, however commonplace. Unhappily, all medical "specials" are not Fothergills; but, happily for many men, ordinary jour-

nalism is to a great extent a mechanical art, requiring little letters and much scissors and paste. This open and candid confession may perhaps soften the cynic harshness of the critical journal, the name of which has unfortunately escaped from memory.

Turning to the journals—by force of habit—it is evident that the decision of the General Medical Council to add another year to the course of study has made no little stir. One method of reducing the number of recruits is to render the curriculum as uninviting as may be. The addition of a fifth year is certainly a serious monetary tax on those entering the profession, as well as another fence to be surmounted before the coveted license to practice is gained. Some of the lay journals, in commenting upon the subject, are loud in their outcry against the injustice of adding the cost of another year's work, which had not been taken into the calculations of students or of their friends. It is quite improbable, however, that fresh regulations would apply to those who have already entered upon their studies. Hitherto, medical legislation in this country has not been retroactive. The chief reason for the change is that the ever-increasing field of knowledge demands an extended time for study. Specialism in every branch has advanced by leaps and bounds, and a fair insight into, at any rate, their broad principles is expected of all well-educated practitioners. At the same time, opinions differ as to the best way of devoting the extra twelve months. Many men maintain that the time would be best spent in practical work.

Whatever be the outcome, one is pleased to see that the important subject of medical education is receiving practical consideration. Like most other institutions rendered venerable by the weight of many ages, the whole system has become loaded with incongruities and chronicisms and abuses. One is loath to believe that so progressive a profession will allow this state of things to continue when once its defects have been clearly exposed. Amongst other burdensome inheritances forced upon the modern student is the compulsory attendance upon lectures. When books were scarce and pupils proverbially lazy the custom was not without its advantages. But now books are plentiful as the sands of the seashore, and, as a matter of fact, the lecturer not infrequently reads to his class a chapter from one of his own volumes. And nowadays—*O tempora!*

*O mores!*—the student who does not read is almost as rare a bird as the worker was in days of yore. It is, undoubtedly, to the interests of lecturers to stick to their guns, for in many cases class fees form their main source of emolument. The Council has fallen in with the recommendation of the Education Committee that not more than three lectures should be delivered weekly upon any one subject. Sir William Turner is reported to have declared he would decline to be bound by any such recommendation, which is probably not worth the paper it is written upon, however meritorious in intention. The anatomy Professor of Edinburgh University is one of the few men that most students could listen to with advantage six days a week through the six months of a winter session. His fine descriptive powers, his wonderful grasp of detail and his eloquence are of more value than many books. Still, the fact remains that lecturers exist who are unversed in the simplest rules of rhetoric and with whom the gift of teaching does not lie.

The subject of education is not the only one—according to Dr. Mortimer Granville—that is clothed with a parasitic growth of prejudices. The ordinary dietetic treatment prescribed for gouty patients, he maintains, is a delusion and a snare. It is useless to forbid sugar, since there is 70 per cent. of convertible starch in bread. He observes that flesh-eating animals produce little uric acid, while the herbivora are noted for the reverse. Whiskey he condemns; sound claret is to be taken in moderation, and, even well-matured port wine. Butcher meat may be eaten at discretion, while sugar is recommended as a natural stimulant to the kidney-cells. It would, perhaps, be going too far to say that the science of dietetics is in its infancy, yet the ordering of port to gouty patients somewhat startles one by its revolutionary air.

Apart from the obscure chemico-physiological problems involved in the study of dietetics, the surest guide seems to be that of practical experience. Since the appearance of Dr. Granville's article not a few medical men have come forward to confirm his statements. One man who has been a martyr on and off for seventeen years remarks pithily that he has tried great moderation in every way and had the gout; while he has been less moderate and still had attacks. The whole matter merits careful investigation.

D. W.

## PERISCOPE.

### A Plea for Better Wives and Mothers.

Dr. Grace Danforth, of Granger, Texas, in a sensible article in the *Texas Courier-Record of Medicine*, June, 1890, says: The trend of modern medical thought is towards prevention rather than cure. In some departments notable progress has been made while in gynecology very little has been effected. Women are so accustomed to be a bundle of aches and pains they have accepted the condition as a dispensation of Providence. Men are beginning to wonder if their inalienable rights do not include a healthy wife. Too many find life hardly worth living, liberty a delusion and happiness an unmeaning term, in the vain attempt to satisfy the vagaries of an invalid. To the credit of the majority they accept the situation with fortitude and make the most of what little domestic happiness remains to them.

The past educated man, and from his necessities he constructed a costume to meet his wants. The present is attempting to educate woman, but in the matter of costume she has her own as well as masculine prejudice to admonish her to be womanly and follow in the footsteps of her mother. In the vocabulary of the future it will be "unwomanly" to be an invalid. Our mothers have not covered themselves with glory by a contribution of healthy wives to the present generation. Perhaps the future may give us a much more desirable definition to the term "womanly" than the past has done. Female education has been confined to domestic work and "accomplishments," which mean a polishing for society with a view to matrimony. Making the marriage relation a success has received small consideration.

It is no new truth to the medical fraternity that woman's costume ruins her health. It is somewhat a matter of surprise that the profession do so little in educating women to better conduct in the matter, but when it is remembered physicians are estimated by their pills and powders, while advice falls upon deaf ears, it is no wonder they grow weary of bestowing it. It is claimed self-interest paralyzes effort in this direction, but physicians know it is a more potent factor in human affairs than even

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self-seeking-woman's ignorance, and bondage to fashion.

We wonder at the prevailing idea among women, that a compressed waist adds to their beauty. It was not æsthetic culture but practical demand that created the deformity. When society emerged from the chaos of the dark ages, men put a premium upon woman's virtue by refusing to lead to the marriage altar a woman who had sullied her fair name. Marriage was her only hope, and pleasing those in power her only resource for securing it. Slender waists were cultivated as a means of advertising maidenhood till the disfiguration lost its significance and was regarded as beautiful. Husbands were proud of wives whose waists they could span. As men encouraged it, and women did not realize the fearful wrong perpetrated against nature, small was the hope for improvement.

Some forty years ago a few earnest women, realizing the necessity for reform in woman's dress, adopted the Bloomer costume. It met every hygienic requirement, was light and warm, emancipated waists and hips, equalized the circulation and gave freedom to the limbs; but it was not beautiful, and men as well as women combined to ridicule it out of existence. It was too much for human endurance, brave as its advocates were, to be a free menagerie every time they appeared in public.

At present Madame Jeness Miller is attempting in a more conservative manner to correct the evils of a woman's costume. She does not shock prejudice by a radical departure from fashion in the outer garb, but frees the vital organs from compression and suspends the clothing from the shoulders. The tight sleeve, which interferes with motion and circulation, has proved a blessing in disguise. It has taught women the advantage of knitted underwear over the old unyielding fabrics.

When women will consent to machinery monopolizing this field of labor, a vast gain of health and time will accrue to the human family. There will be a decrease of work for the gynecologist caused by the sewing-machine while the neurologist and oculist will realize in their several specialties the improved order of things.

All these evils have been recognized by the medical profession, but a practical age is asking, What is to be done about it—how are these evils to be corrected? Medicine has exhausted its resources in pills, powders

and surgical appliances, yet still the evil is increasing in every direction. Symptoms are treated because the cause cannot be reached by ordinary means. It is a case similar to that of Oliver Wendell Holmes, where treatment should be inaugurated two hundred years before the patient is born. The problem of woman's physical emancipation must be solved by women, but they cannot do the work ignorant of physiological law.

The medical fraternity is a potent factor in educational interests, as every teacher can testify, yet they have submitted too long to a curriculum arranged by professional teachers who sacrifice the physical branches to mathematics and languages. Our boys as well as our girls, need a better knowledge of physiology, but it is woman's cause that is under consideration. Could not the medical fraternity use its influence in having anatomy, physiology, hygiene and chemistry better taught in our schools and especially in our female seminaries? What better use could be made of medical women locating among us than to utilize them in schools where they can reach our girls in a way male practitioners cannot? During school life our daughters emerge from girlhood to womanhood, a critical period in female development. Were a woman in charge of the health of the institution there would be no hesitation on their part in seeking advice early enough to avert many of the mistakes made through ignorance, blasting health and sometimes the hopes of wifehood and motherhood.

Many mothers from a false delicacy fail to instruct their daughters upon plain physiological facts, that every girl upon coming to woman's estate is entitled to understand. A knowledge of the most sacred laws connected with our physical being is left to the tuition of companions and servants. Men realize that innocence and ignorance are not synonymous terms, but women still confound them. With the progress of our present civilization our daughters demand better instruction than their mothers received to make a more just discrimination between modesty and prudery. Unborn generations are demanding better mothers.

#### Experimental Studies in Tuberculosis.

The *Weekly Abstract of Sanitary Reports*, June 13, 1890, contains a translation from



*La Rivista Internazionale d' Igiene*, Naples, May, 1890, which states that at the Heidelberg Congress of German naturalists and physicians, Schottelius stated that some years ago he instituted a series of experiments with tuberculous lungs interred in a wooden box at a depth of five feet, the usual mode of sepulture of bodies. After two years and a half he removed from the earth a quantity of tubercule bacilli, for the most part spore-producing. From this material he obtained pure cultures which furnished positive results in 80 per cent. of his experiments in inoculation. He is now engaged in investigations with the object of ascertaining whether the virulence resides in the bacilli taken from the soil or in their spores. Soyka expresses the opinion that the greater number of the bacilli perish, but that some possess durability and may recover their virulence under favorable conditions. Gärtner has observed bacilli in a cemetery abandoned for twenty-five years. As a practical outcome of his investigations, Schottelius advises the disinfection of bodies of persons dead from infectious diseases.

Gebhardt has experimented on the sputum of consumptives, his object being to test the virulence of the sputum in different grades of dilution, and to ascertain whether the potentiality of the tuberculous virus is essentially modified by the organ first infected—that is to say, by the manner of infection. With this object he practiced hypodermic and intraperitoneal inoculation and experiments in inhalation and alimentation, and ascertained that the subcutaneous connective tissue, the peritoneum and the lungs are inclined to receive and multiply the tuberculous virus in about an equal degree, while the digestive apparatus offers resistance. Hence tubercular virus may, especially in small quantities, pass through certain organs without provoking local alterations. As the point of ingress is not always the seat of the disease, pulmonary tuberculosis is not always to be attributed to infection by inhalation.

Sputum which contains bacilli is enormously infectious, retaining its virulence even in dilution of 1-100,000, apparently without regard to the manner of infection. The virulence of the sputum being in proportion to the quantity of bacilli present, Gebhardt employed pure cultures of the bacilli of tuberculosis, on the hypothesis that equal quantities of the same culture contain equal quantities of bacilli. With a subcutaneous inoculation of 1 c. c. of a di-

lution in the proportion of 1-400,000 and an inhalation of 0.5 c. c. of the same dilution in a culture of agar-agar he obtained positive results. Hence the pure cultures retain their virulence when enormously diluted.

Malassez and Vignal desiccated the sputum of tuberculosis, moistened it with water, again desiccated and pulverized it, and this repeatedly, endeavoring to realize, as far as possible, the conditions to which the sputum daily ejected in our streets is subjected. After successive desiccation and humectation the bacillus of the sputum retained all its virulence.

With regard to the penetration of tuberculous bacilli into the organism, Dobroklonski states, as the result of his experiments in the Cornil laboratory at Paris, that tuberculosis may attack the organism by way of the digestive apparatus. For this infection to occur, no lesion of the intestinal wall, epithelial desquamation, local modification, nor anterior inflammation is necessary. The tuberculous virus (bacilli and spores) may easily traverse the completely normal epithelial lining of the intestine, but it does not determine inflammation unless it remains for a length of time in contact with the intestinal wall. Dobroklonski asserts that the tuberculous spores and bacilli do not penetrate the organism by any fixed means, but that they are carried by the current of the lymphatic system, and, being arrested by the tissues, determine in them the formation of tubercles.

As a natural inference from Hirschberg's experiments demonstrating that tuberculous cows, or cows infected with tubercular phthisis, produce, in 55 per cent. of cases, infectious milk, it was supposed that milk from large dairies would contract virulent properties from the infectious milk of one tuberculous cow. A series of experiments, conducted by Gebhardt, under the direction of Bollinger, in the Pathological Institute of Monaco, show that tuberculous milk loses its virulence at a certain dilution. The mixing of milk, practiced in large dairies, diminishes the danger, and in most cases renders the milk innocuous. Milk served by large dairies is always to be preferred to the continued use of milk from the same cow.

Studies in the transmission of tuberculosis from animals to men by means of tuberculous milk directed the attention of hygienists to the derivatives of milk, the most im-

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portant of these being butter. Gasparini inoculated guinea-pigs with butter containing the bacillus of Koch, and by microscopic observation verified tubercular lesions in almost all cases.

Referring to his studies of the infectious property in the flesh of tuberculous animals, Kastner stated that the object of his experiments was to ascertain if such flesh contained virus, and to what extent the consumption of such flesh, as meat, was dangerous to man. From the results of his experiments he concludes that the danger is slight, unless the nodules of tuberculosis are formed in the meat, which is rarely the case.

### Genital Origin of Asthma in Women.

Dr. Charles A. L. Reed, of Cincinnati, Ohio, has a paper on the relation of disturbances of the generative organs of women to the development of asthmatic attacks in the *Cincinnati Med. Journal*, June, 1890.

He says that the form of paroxysmal dyspnea, called asthma, is now very generally recognized as a neurosis. The absence of any definite trophic lesion within the lungs forces the view that the essential seat of the disease is in the pulmonary plexus of the pneumogastric. The clinical characteristics of the asthmatic seizures, taken in connection with the inter-paroxysmal period, forces the view that the involvement of the plexus extends no farther than a morbid functional perturbation. Back of the actual disturbance, however, must exist an abnormal sensibility of either the sensory or motor filaments or both. It is this abnormal sensibility which renders possible the spasmodic reaction from agencies and influences which would produce no effect at all upon a more stable nervous system.

Given this hyperæsthetic segment in the great nervous chain, how is it influenced that bronchial spasm results? A particle of dust or a gaseous exhalation may come in contact with the sensory filament of the pulmonary plexus, the impulse may be transmitted to the nearest ganglion, transmuted into a motor impulse, returned to the tube and induce tetanic contraction in its muscular walls. An emotion may induce not only cerebral excitation, but centric irritation of the medulla at the origin of both the sympathetic and the pneumogastric; over these joint highways of transit, an impulse is started to the remotest nooks and

crannies of the body; in the majority of organs little or no change is produced, but through the intervention of these hyperæsthetic pulmonary filaments, a disproportionately greater change is induced in the lungs; bronchial spasm takes place and the dyspnea of asthma is at once experienced. Or the impulse may come from below. A heavy supper with resulting indigestion causes an irritation of the gastric branches of the vagus.

The exaltation of reflex sensibility which comes with sleep favors the transmission of the impulse over that great telegraphic line from the stomach to the lungs, called the pneumogastric, and with the midnight hour comes, not calm repose, but a gasping fight for air. But these disturbing influences may originate far below the reach of the pneumogastric. Who has not seen the victim of a renal colic, otherwise healthy, gasp for breath; and who, at the same time, has not drawn a mental picture of the telegraphic circuit from the cramped kidney, over the renal plexus, up the great sympathetic, out over the pulmonary branches to their anastomosis with the pulmonary branches of the pneumogastric, and thence to the rudely inhibited bronchial muscles? If now, we introduce the additional factor of hyperæsthetic motor filaments in the pulmonary plexuses, we shall see instead of an occasional interruption in the respiratory rhythm, a tetanic contraction of the muscular coats of the bronchi, and all the essential phenomena of an asthmatic seizure. But the source of irritation may be even farther down this tract and this brings us up to the intra-pelvic or genital origin of asthma.

Hyde Salter, in discussing the etiological influence of sex, states, that of 207 cases, 138 were males and 69 were females—just two to one. After explaining that males are more exposed to such exciting causes of asthma as labor and exposure, he adds: "an asthmatic nervous system is a mobile nervous, sensitive system, and certainly the female nervous system is more mobile and sensitive than the male. Consistently with this, I believe it will be found that idiopathic asthma—the pure neurosis—is as common in women as in men, and that the cases by which so large a preponderance is given to men, are cases starting from bronchitis. This view is fully borne out by the cases that have come under my observation. Twenty-three of my patients, of whose cases I have recorded notes, were between twenty

and thirty years of age; of these, nine were males and fourteen were females. Between fifty and sixty years of age, I had nineteen patients; of these sixteen were males and three were females. Thus, at the period of life at which the lungs are the least likely to be organically affected but at which the nervous system is more excitable, the females exceed the males—in the proportion of three to two; while at the time of life when organic diseases of the lungs is likely to exist, the males greatly exceed the females—in the proportion of five to one."

Dr. Reed contributes reports of five cases to the literature of this subject, and concludes by expressing the opinion that there occur certain cases of asthma in women, limited in number, in which there is a distinct intra-pelvic origin of the disease; that the causal relationship of the two conditions is indicated by either the sequent or coincident occurrence of intra-pelvic and respiratory symptoms; and that the cure of the bronchial spasm, whether intermittent or constant, can be effected in these cases only by rational treatment of the causal conditions within the pelvis.

#### Treatment of Rheumatism with Phenacetin.

Rifat, according to an editorial in the *Boston Medical and Surgical Journal*, June 26, 1890, reports the results of recent experimentation with phenacetin in rheumatism, both acute and blennorrhagic. He has treated sixteen cases; in three of these all the joints were more or less affected; in four only two or three joints were swollen and painful. In the three grave cases, which were attended with a very high fever, he was obliged to give large doses, fifteen grains every three hours day and night. In six of the cases he gave the fifteen-grain dose only every four hours. There is, he says, extreme tolerance by the stomach of phenacetin—an advantage over antipyrin. It is well to begin treatment by giving only forty-five grains a day, that is, fifteen grains every three hours till three doses are taken. This dosage is, however, insufficient in rheumatic polyarthritis. Where he begins with forty-five grains *per diem*, he increases by fifteen grains a day until the pain has ceased, and the movements of the joints are restored. Ordinarily by the fourth day, when the daily dosage of ninety grains is reached,

there will be noticed disappearance of the pain, freedom of movements and absence of heat and swelling about the joints.

The maximum dosage, which is determined by the state of amelioration of the patient, is continued during the three following days—exceptionally, for a week; then the doses are gradually decreased by fifteen grains a day until the quantity of forty-five grains *per diem* is reached, and the medicine is continued in that daily amount for a week, when it can generally be discontinued. In very severe cases it is necessary to continue the augmentation of doses till the fifth day, when the daily quantity has attained two drachms.

The treatment as above described demands, in cases of average intensity, seventeen days; in grave cases, twenty-one days. It will thus be seen that the mean duration of grave cases does not exceed twenty-one days. If we compare these results with those obtained by Guttman with salicylic acid, whose mean duration was thirty-five days, and with antipyrin which gave a mean of twenty-five days, we see that phenacetin administered in the manner above described, appears to be the remedy to which preference should be accorded.

As for the secondary effects of these large doses of the drug, Rifat sums them up as follows: In patients treated with phenacetin, there may be observed three sorts of phenomena imputable to the secondary action of this medicament, and which are: profuse sweating, cyanosis, and uremic accidents. Abundant sweats, especially in cases complicated with high temperature, are the rule; these are due to the hyperthermia, and when once the temperature falls to the normal, the sweating subsides. The sweats are wanting in apyretic rheumatism, and when they occur in the febrile form, they do not contra-indicate the continuance of the medicine, whether this be phenacetin, antipyrin or salicylate of soda. There is less liability to cardiac or other visceral complication when the remedy is pushed.

Cyanosis is a rare accompaniment of the administration of phenacetin. Rifat has not seen it in any of his rheumatic patients; in fact, he has never witnessed it but once, namely, in a case of typhoid fever. Uremic accidents are also very infrequent. They have, now and then, been witnessed in rheumatic patients with arterio-sclerosis and contracted kidneys as the result of suppression of the urinary excretion by the administra-

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tion of phenacetin. Hence, it would be necessary when giving this remedy in large doses to nephritic patients to have surveillance of the renal functions, and to suspend the medicine if uremic symptoms should appear. Relapses are not very frequent, if the physician takes the precaution to continue the phenacetin after the method above indicated. If, however, the remedy be too early suspended, a relapse will be almost certain to follow. The same result has been noticed when salicylic acid or antipyrin has been given.

As regards blennorrhagic rheumatism, Rifat concludes, from an observation of three aggravated cases that, in cases where salicylate of sodium has completely failed, phenacetin may have a real curative action. This disease is often most intractable, being the opprobrium and despair of the physician; though its pathogeny is doubtless widely different from that of acute rheumatism, yet in the cases reported by Rifat, phenacetin gradually pushed to six and eight grammes a day (certain auxiliary local measures, as compression, being also employed) gave most satisfactory results, the pain and swelling rapidly subsiding, sleep and the power of movement returning. Unfortunately, three cases is too small a number to warrant a definite conclusion.

### Naregamia: A New Expectorant.

Dr. Schoengut, of Vienna, has been recently experimenting with the tincture of naregamia, which is prepared from the bark of the *naregamia alata*, a shrub indigenous to India. As the pure tincture is too stimulating it is important to dilute it, as with cherry-laurel-water, in the following prescription:

R Tincture of naregamia,  $\mathfrak{m}$  xvi-xlv (1-3 grams);  
Cherry-laurel-water,  $\mathfrak{f}$   $\mathfrak{z}$  iii-f  $\mathfrak{z}$  i (10-30 grams).  
M. Sig. Ten drops every hour.

Dr. Schoengut, the results of whose observations are given in the *Journal de Médecine*, March 23, 1890, employed the drug as an expectorant in twenty-four cases of various affections of the respiratory organs, the amount of the tincture given being from 16 to 50 minims in twenty-four hours. The expectorant action of the drug was manifest in every case, especially in those characterized by scanty secretion and severe cough, or where the expectoration was viscid and stagnant. In cardiac affections, accompanied by catarrh of the respiratory tract,

the tincture of naregamia acted most beneficially. Admirable results were obtained by use of the drug in cases of pulmonary emphysema.

In tuberculous subjects, the action of the tincture was only temporary. Naregamia renders the bronchial secretion more fluid and less viscid. The improvement in the expectoration is always followed by diminution of the respiratory difficulty.

The circulation, the pressure of blood, and the digestion are not affected by the drug, which has no toxic action whatever.

### Abscess under the Palmar Fascia.

Dr. H. H. Spiers, of Edinburgh, Ohio, writes in the *Cincinnati Lancet-Clinic*, June 28, 1890:

Every surgeon of experience has met one or more cases of the above affection. The strong palmar fascia prevents any great swelling, and in a measure precludes palpation, so that it is difficult to diagnose the presence or absence of pus with certainty. If seen late the lance is commonly resorted to. If seen early hot fomentations or poultices are usually applied for a time and the use of the lance postponed.

In my experience poultices and fomentations amount to but little. In the use of the lance, whether early or late, parts are severed that never again unite; the hand is left disabled as a consequence. If the abscess be allowed to remain unopened, the pus burrows into, or so paralyzes the muscles of the hand, that its use is ever after limited. In either case a claw hand is the result.

I have seen a number of cases and have closely observed the results of treatment. To me no method has proved so satisfactory as the following: Pass a large needle, with a curved point carrying a double thread of surgeon's silk, near or into the annular ligament, well into the tumor and let it emerge between two of the fingers—preferably the ring and the middle. The operation is brief, the pain little, but an anæsthetic may be used or a hypodermic injection of morphia or cocaine may be given if preferred. The double thread is left long, and is knotted at both ends. By alternately pulling the thread backwards and forwards any pus along the line readily makes its exit. The parts gradually settle back to their wonted place and recovery is complete.

This operation has the merit that it may be used early or late. Of course, it will not retrieve any damage already done.

I have frequently resorted to this method in tumors of the face and neck, where it is dangerous to lance or where a scar is not desired, usually with good results.

### Operation for Loose Cartilage.

At the meeting of the Berlin Medical Society, July 2, 1890, Prof. Max Schüller presented a young man, twenty-three years old, in whom he had opened the left knee-joint for an irreducible movable cartilage of the joint, wedged in between the articular surfaces of the inner condyles. The movable cartilage could not be seen in the unopened joint, but Dr. Schüller supposed from the history of the case, which had given the signs of a free and movable cartilage, and from the symptoms which were present when he saw the patient (sudden pain in inner side of the left knee-joint, continuing with impossibility of using the limb, and impossibility of extending the knee, which was held in a semi-bent and somewhat abducted position), that a loose cartilage must be squeezed between the inner articular surfaces. After having failed in an attempt to effect reduction by manipulation, he made, with strictest aseptic precautions, a longitudinal incision of from 10-12 centimeters long between the patella and the internal lateral ligament, opened the capsule of the joint, and freed it with a few small incisions from the condyles, and then abducted the leg forcibly while in a semi-flexed position. By this proceeding the inner condyles projected out of the opening of the capsule and were separated, so that it was possible to look through a small space in the opened joint. The loose cartilage, a pear-shaped piece of cartilage on a fibrous pedicle, was placed on the eminentia inter-condylar tibiarum and now projected in the space between the inner condyles. It was cut away, then the semi-lunar cartilage, which was a little displaced in consequence of disturbance of the capsule, was sewed again at the capsule and the joint was closed.

Four weeks later, after a healing by first intention without any fever, the patient began to walk. Four months afterwards he walked quite well. Now he can move the knee freely and easily to a right angle and can take part in all sports and dances with-

out any trouble. Dr. Schüller believes that this manner of opening the knee-joint, which allows an inspection of the lateral parts of the joint between the condyles without any lesion of the great ligaments, will be also of use in cases of so-called internal displacement, of sub-luxation and breaking off of a meniscus with irreducible entanglement between the articular surfaces. In such a case quite recently some one has done an excision of the whole knee-joint. Schüller believes that his mode of opening the lateral part of the joint renders unnecessary excision in these cases and will give a surer help than fixation-apparatus, which is not very satisfactory in its effects.

### Intubation for Croup.

Dr. Waxham read a paper at the Nashville meeting of the American Medical Association, in which, to those competent to do the operation with delicacy and skill he recommended intubation in preference to tracheotomy at all ages, under all conditions, and under all circumstances. In support of this advice he fully recorded two hundred and eighty-five cases with one hundred recoveries, or thirty-five per cent. These cases were not selected, the majority of them being among the poor and destitute, where tracheotomy would hardly have been considered. The ages ranged from five months to twenty years, and the operations were not performed early, but as a last resort. The ages were as follows:

Under 1 year		10 cases, with 3 recoveries.			
Between	1 and 2 years	37	"	"	9
"	2 " 3	46	"	"	10
"	3 " 4	47	"	"	17
"	4 " 5	59	"	"	23
"	5 " 6	27	"	"	14
"	6 " 7	18	"	"	7
"	7 " 8	20	"	"	9
"	8 " 9	7	"	"	4
"	9 " 10	6	"	"	3
"	10 " 11	3	"	"	1
At	12	2	"	"	0
"	13	1	"	"	0
"	14	1	"	"	0
"	20	1	"	"	0
		285		100	

Among those to recover were two infants of nine months and one of ten months. There were ninety-three cases under three years, with twenty-two recoveries. There were one hundred and ninety-two cases over the age of three years, with eighty-eight recoveries.

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portant that brevity and actual interest shall characterize communications intended for publication.

As a consequence a number of physicians, who thought they might some day wish to attend patients in New Jersey, lost no time in crossing the Delaware with copies of their diplomas, and the small fee required by the existing law, for registration with the Prothonotary of Camden county.

There are certain defects in the New Jersey law which somewhat modify the gratification the friends of medical reform might naturally feel at the passage of any law establishing a State Board of Medical Examiners. We note that there seems to be no provision at all for preventing men from practicing without examination who claim that they have already practiced in New Jersey at any time. The expressions of the law refer to those "hereafter commencing" the practice of medicine. We are told also that the law was pushed through the Legislature by a few physicians who think they have special influence with the present Governor, and it is feared that it was intended rather to forestall the passage of a better and more thorough law than as a real advance. It is a cause of complaint that it formally recognizes as "schools of medicine" the homeopathic and eclectic sects and gives a single representative of either one of these



small bodies the power to prevent the licensing of any applicant—because a unanimous vote is requisite for obtaining a license—while the provision for a "Committee of Review," in case of appeal by a rejected applicant, authorizes the creation of a tribunal in which each of the three bodies recognized by the law is represented by one representative and might furnish no relief whatever to an applicant unjustly rejected.

These certainly seem to be defects in the law referred to; but we sincerely hope that they will not be found to be irremediable. We believe it would be better in any State to leave the appointment of a Board of Medical Examiners to the Governor, with no restrictions except such as would be imposed upon him by public sentiment, and we deprecate the mention of different sects in a bill which ought to have nothing with their contentions. We think also that the provision for a unanimous vote in favor of a candidate might be changed; although the law always presumes faithfulness in its execution, and under these circumstances it ought not to be too much to ask that intending practitioners of medicine should be prepared to secure the approval of the whole of a small number of examiners. No law could be framed which would not be capable of abuse, and we believe the interest of the profession in New Jersey will be best subserved and the good of the medical profession most advanced if the new law in that State is supported where it is good and amendments are advocated where its provisions are imperfect or unwise. We regret that it does not appear to be all that some of us might wish; but think it may prove useful in itself and lead to something better in the future.

#### PROTECTION FOR SCHOOL CHILDREN.

Those who rule the affairs of the cities and towns of the United States have no more sacred duty than to protect the lives of the children who attend the public schools.

A more defenceless set of subjects no ruler has, nor any which appeals more strongly to every instinct of manliness and generosity. Notwithstanding this, it is no secret that in many places the directors of the public schools, or those called by whatever name who have the management of them, are largely selected from the list of men who are supposed to deserve either reward or encouragement in the lower walks of a political career. This is undoubtedly the case in the large cities, and to the shame of New York and Philadelphia it may be said that the object of these directors or managers seems at times to be rather to provide points from which their friends can tap the public crib than to provide means to better the mental and physical condition of those for whom the schools are supposed to be provided. It may be that this statement will in a measure answer the inquiry of our contemporary, the *Philadelphia Press*, July 16, as to the point of responsibility for the fact that the Board of Health recently declared twenty Philadelphia schools to be in a condition prejudicial to public health.

These schools, the *Press* says, hold about 10,000 children every day of the school year, and the statement means that Philadelphia has enough children at school in disease-breeding buildings to fill a small city. But this is not all. Two years ago the Medical Inspector reported ten of these schools in just the condition in which he now finds them. The Lincoln School, in the Fifteenth Section, with its 944 children, needed drainage then, and it still needs it. It was then understood that the required improvements in drainage would be completed in the vacation. Two vacations have passed, and its water-closets are still in the cellar, and in a disgusting condition. Philadelphia has 920 girls and boys in the Thaddeus Stevens School, in the same section; and the latrines which were in the cellar two years ago are there yet. Here are nearly 2,000 children who for two years have been kept in conditions shown to be unhealthy,

by an inspection in 1888, which an inspection in 1890 finds still unhealthy, nothing effectual having been done in the interval. This, the *Press* adds, is true of eight other school buildings, while three schools in the Second Section, with 1,293 pupils, turn up after two years with just the same defects, each a gross danger to health, which no reader of these lines would tolerate in his own house, but which the city has left for two years.

It is with pleasure that we note the attention given by an influential paper to the subject of the unsanitary condition of our schools, and we sincerely hope that it will be able to as thoroughly arouse the moral sense of the school authorities as the importance of the exigency requires. The sickness and death for which such a state of affairs as is reported may be responsible, we would not undertake to estimate; but it is easy to believe that it may be very great and must be great enough to be a serious menace to the children in the community.

#### SPERMATORRHOEA AND IMPOTENCE.

By the term spermatorrhoea is meant a real or apparent discharge of seminal fluid, occurring without voluntary sexual excitement. Two varieties are noted: the true and the false; the latter, being simply a prostaticorrhoea, destitute, of course, of spermatozoa. Cases of true spermatorrhoea are of rare occurrence. Its cause is various, generally some local irritation, such as masturbation; a diseased or disordered condition of the genital organs; constipation; acute general prostration—as after typhoid fever; overwork or any severe nervous strain, etc. The symptoms are obvious, and, in a genuine case of this disease, require active treatment, consisting of hygienic, general and local measures. The steel sound and electricity, locally applied, give tone to the parts. Ergot, in doses of from two to five grains daily, in atonic cases, is well spoken of by competent authorities.

By pollution we mean a nocturnal or diurnal

involuntary emission of semen, attended by a venereal orgasm, masked to a greater or less extent. Nocturnal emissions are, in the majority of cases, simply physiological; but if caused by excessive indulgence in venery, or due to masturbation, they may become pathological. It is only then that treatment is indicated, which, in the main, should be directed towards purifying the thoughts of the patient, elevating his tone and, if possible, by effecting his marriage; for, very few married men, if any, suffer from this affection.

Diurnal pollution is rare and is always pathological. Cases are on record in which the presence of a woman, the fondling of a child or the mere thought of a certain woman would produce this unfortunate condition. Moral education, combined with the use of the steel sound, astringents, locally applied to the prostate and a general tonic, usually suffice in effecting great relief, if not an entire cure of this disorder.

An impotent person is one who cannot beget children because he cannot perform the sexual act properly, no matter what the obstacles may be, whether he have spermatozoa or not. On the other hand, in sterile persons, the inability to beget children is due to the absence of spermatozoa in the semen of the individual. It is true, that these two conditions may be associated in the same person; but they are distinctly two separate diseases. With a clear understanding of these two affections we can severally consider each of them.

Impotence, like spermatorrhoea, may be either true or false. True impotence may arise from a variety of causes: absence of the penis; too large or too minute an organ, preventing the act of intercourse; extreme epispadias or hypospadias, etc. Age is also a potent factor in causing impotence; hence, it is not a rare condition in old age; for the vigor necessary to bear the nervous excitement attending the act of coitus is wanting. There are, however, some remarkable in-

stances on record of men who are reported to have been capable of the reproductive act in very advanced life. Thus, Zadislas, King of Poland, at the age of ninety years, married his second wife and had two sons. Cato, the censor, is said to have had a son at the age of eighty years.

The treatment and prognosis in this class of cases under consideration must necessarily vary with the individual case. For want of space, we shall therefore be obliged to refer our readers to special works upon the subject. The greater number of impotent cases, with which the general practitioner comes in contact, are those of false or supposed impotence. In such cases the impotence is only imaginary. With persons so affected the utmost delicacy and tact of the physician are called for in order to gain the confidence of his patient; which once done, success in the cure of the individual is assured. Among the causes of false impotence may be mentioned sexual indifference, either temporary and spontaneous or more or less prolonged, as a result of sudden shock or excessive emotion; and lack of affection for the individual with whom copulation is attempted. Drunkenness, which is not habitual, may induce temporary impotence; and so may unnatural excitement of the sexual functions or protracted chastity.

The treatment of these cases is, first of all, to seek out and remove the agencies acting as the prime factors in producing the trouble. Then active exercise of both mind and body, together with attention to hygienic surroundings, will usually, with the form of treatment about to be advised, prove efficacious in curing the patient. Tonic medication is called for, as well as a generous diet. The bowels must be carefully regulated. Dry frictions of the entire body, by the use of the flesh-brush or massage, will be found useful. Sea-bathing is often beneficial. The main point, however, is to give the patient confidence in both his physician and himself.

There is left for our consideration the

subject of sterility, which condition may arise from malposition of the testicles, obstruction in the excretory ducts of the testicles, obliteration of the canal of the epididymis, after double gonorrhoeal epididymitis, and azoöpermism or the condition in which no semen, or at the best, unproductive semen, is secreted. For the treatment of these conditions the reader is referred to works specially treating upon these special subjects. In concluding this article, we would strongly impress the practitioner of medicine with the importance of the subject of genito-urinary diseases and the relation which he, as medical advisor of a community, must assume with the general public. The cure of disease is not the only object of the physician's effort; its prevention is often a higher and nobler one.

#### ETIOLOGY OF CHOLERA INFANTUM.

In this issue of the REPORTER is published an interesting paper by Dr. George Troup Maxwell, of Jacksonville, Fla., which contains matter well worth thinking about. In the Editorial which he refers to and criticises, we presented the view of the etiology of cholera infantum which is generally accepted by careful students of the subject. But in this, as always, the REPORTER did not wish to do more, or to intimate that differing opinions are not worthy of respect. There are, we well know, difficulties inherent in the theory adopted in the REPORTER, and Dr. Maxwell has very ably called attention to some of them. There is also much to be said in favor of the theory which he presents. The subject, however, is still in need of elucidation, and the true theory is likely to be discovered all the sooner if the matter is carefully and patiently and considerably discussed by men who are now of different minds. The columns of the REPORTER are open to all such men; and it will be a good thing if those of its readers who have something to say (briefly) will present their facts or their opinions to their fellows who consult the same columns.



## BOOK REVIEWS.

[Any book reviewed in these columns may be obtained upon receipt of price, from the office of the *REPORTER*.]

**CYCLOPÆDIA OF THE DISEASES OF CHILDREN, MEDICAL AND SURGICAL.** The articles written especially for the work by American, British and Canadian authors. EDITED BY JOHN M. KEATING, M. D. Vol. III. Illustrated. 8vo, pp. xv. 1371. Philadelphia: J. B. Lippincott Co. 1890.

The present volume includes Diseases of the Digestive System, Diseases of the Genito-Urinary Organs, the Blood, Surgery, and Diseases of the Osseous System and of the Joints. It is impossible to give an adequate review of it, space permitting scarcely more than a notice.

Three of the articles strike the reviewer as especially noteworthy: they are L. Emmett Holt's, on the Diarrheal Diseases, acute and chronic; Enlargements of the Liver, by J. H. Musser; and Diseases of the Blood, by J. P. Crozer Griffith.

Dr. Holt has departed from custom by omitting a separate description of dysentery. He says: "The common view that in diarrhoea we have to do with lesions in the small intestine, while the lesions of dysentery are in the colon, is entirely overthrown by the *post-mortem* findings. The truth is, that in by far the largest number of cases classed clinically as 'diarrhoeas,' the principal lesions are found in the large intestine, while in the cases of so-called 'dysentery,' lesions are almost invariably found in the lower ileum as well as in the colon." Regarding the etiology of diarrheal diseases, he says: "Their chief exciting cause is something to the development of which two things have a fixed and constant relation, viz.: a certain degree of atmospheric heat and the practice of artificial feeding. Both these conditions are necessary. We believe the chief causative factor to be bacteria, and that these act in most cases by inducing changes in the food." The author expresses his own views clearly but moderately, and gives due weight to the opinions of others. The whole article is an admirable presentation of a most important subject.

The article on Enlargements of the Liver, by Dr. Musser, includes the most important affections of this organ which occur in childhood, namely, congestion, fatty and amyloid liver, hydatid disease, abscess, and tumors. The author gives a brief description of the liver in childhood, and then speaks of the diseases which simulate enlargement before treating of enlargement of the liver itself. The literature has been searched carefully, and though organic diseases of the liver are admittedly rare in children, it will be surprising to many to learn that records have been found of over one hundred and twenty-five cases of hydatid disease, of nineteen cases of malignant disease, and of thirty-four cases of abscess (which have been tabulated). This material has been analyzed and the results presented with the clearness and succinctness which the author's long devotion to affections of the liver has enabled him to give to it. The article is a valuable one, and is noticeably free from all padding.

Dr. Griffith gives a most thorough and complete study of Diseases of the Blood. It is a scholarly article from beginning to end, and is beautifully illustrated. Its place in this volume is explained by the fact that the author was asked to undertake it too late to complete it in time for publication in Volume II, where it properly belongs.

The editor, Dr. Keating, has chosen the subject of Diseases of the Uterus, Vagina, and Vulva, and has written a very readable article upon it.

To say that the present volume comes up to the expectations formed by the preceding volumes is in itself warm praise, and we must be content with adding that both editor and publisher are to be congratulated upon it heartily.

**TRANSACTIONS OF THE COLLEGE OF PHYSICIANS OF PHILADELPHIA.** Third Series. Volume XI. 8vo, pp. xxxii, 279. Philadelphia: Printed for the College. 1889.

This volume contains the papers read before the College from January, 1889, to December, 1889, inclusive. In it as usual are a number of valuable communications by prominent Philadelphia physicians. Dr. Charles K. Mills has an elaborate paper on Spinal Localization in its Practical Relations. Dr. Musser has two short contributions, one on the treatment of Peritonitis, and the other on Two Cases of Spinal Meningitis after Caries of the Vertebra. Dr. G. E. De Schweinitz's paper on Headache associated with unusual Visual Phenomena, is an extremely interesting description of certain headaches preceded, accompanied or followed by apparitions. One of the most important papers in the volume is that by Dr. Arthur V. Meigs, on Chronic Endarteritis, and its Clinical and Pathological Effects. Dr. Meigs believes that chronic endarteritis is as much a disease by itself—a separate entity—as are typhoid fever and measles. The disease, he says, does not necessarily involve kidney change, and, if it does, such change is only a very small part of the whole, and is subsidiary to something else. Dr. Meigs gives notes of eighteen cases, and makes out a clear case for a pathological entity which is too commonly spoken of as Bright's disease. Dr. Goodell has a characteristic paper on The Abuse of Uterine Treatment, a subject on which his large experience and ample opportunities for observation well qualify him to speak.

The volume concludes with the Jenks Prize essay for 1889 on the Diagnosis and Treatment of Extra-Uterine Pregnancy, by Dr. John Strahan, of Belfast, Ireland.

**SMITHSONIAN MISCELLANEOUS COLLECTIONS, 708. THE TONER LECTURES. LECTURE X. A CLINICAL STUDY OF THE SKULL.** BY HARRISON ALLEN, M. D. Delivered May 29, 1889. 8vo, pp. 79. Washington: Smithsonian Institution, March, 1890.

Dr. Allen speaks of this essay as a contribution to the morphological study of diseased action. He has studied all the crania within his reach—one thousand nine hundred and six in all—and has noted the anatomical peculiarities which were detected. The study of anatomical variation in the human frame, he says, is a phase of biology, and he holds it to be in this connection as important as any other which may claim the attention of the student of etiology of disease.

The essay is stamped with the painstaking and scholarly exactitude which characterizes all of Dr. Allen's writings. It is an extremely valuable contribution to the study of the skulls of all races from the point of view of a biologist.

THE ODOR OF *ICHTHYOL* may be disguised by oil of citronella. The latter is itself employed, in Ceylon, against rheumatism.

## NOTES AND COMMENTS.

### Medical Examiners' Bill in New Jersey.

The bill for the establishment of a Board of Medical Examiners in the State of New Jersey, approved by the Governor May 12, 1890, provides that hereafter the entrance to the practice of medicine in the State of New Jersey shall be only by a license issued after examination by a Board of nine Examiners, five of whom shall be of what is known as the regular school, three of what is known as the homœopathic school and one of what is known as the eclectic school.

This Board is to be appointed by the Governor, each member to serve for three years, and three going out of office each year. The Board is to meet regularly four times a year and as much oftener as may be necessary.

To pass the Board an applicant must secure the approval of every member of it. Applicants for license are divided into three classes: 1. Graduates of regularly incorporated medical schools, who have graduated not less than five years before the application; 2. All other graduates of such schools, and 3. Medical students taking a regular course of medical instruction. Applicants of the first class shall submit to examination upon materia medica and therapeutics, obstetrics and gynecology, practice of medicine, surgery and surgical anatomy; those of the second and third classes shall submit to examination upon anatomy, physiology, chemistry, pathology, materia medica and therapeutics, histology, hygiene, practice of medicine, surgery, obstetrics and gynecology, diseases of the eye and ear, medical jurisprudence and such other branches as the Board may deem advisable. The questions for examination of applicants of the first and second classes shall be the same in branches common to both. The law provides that after January 1, 1892, the Board shall not license applicants of the second and third classes until satisfactory proof is furnished that the applicant has studied medicine and surgery three years, is of good moral character and over twenty-one years of age. It is provided that students who shall have studied medicine and surgery at least two years, can be examined upon anatomy, physiology, chemistry, histology and

pathology and materia medica and therapeutics; and if their examination is satisfactory to all the members of said Board, it may issue a certificate that the applicant has passed a final examination in these branches, and such certificate, if presented by the applicant when he or she shall make application for license to practice, shall be accepted by said Board in lieu of an examination in those branches.

Applicants intending to practice according to any exclusive system may be examined in materia medica and therapeutics by the representative or representatives of the school to which he claims to belong. To pass the examination an applicant must have the unanimous vote of the Board. Examination papers shall be kept and filed. Rejected applicants shall have the right to appeal to the Governor, who may appoint a Committee of Review consisting of three members, one from each school of medicine, who shall examine the examination papers of each such applicant, and from them determine whether a license should issue; and their decision shall be final. If said commission, by an unanimous vote, reverse the determination of the Board, the Board shall thereupon issue a license to the applicant. The expense of an appeal of this kind shall be borne by the applicant. The fee for the usual examination is to be fifteen dollars for each applicant of the first or second class and twenty dollars for each applicant of the third class.

The law confers upon the Board the right, by unanimous vote, to refuse to grant, or to revoke a license for the following causes: Persistent inebriety, the practice of criminal abortion, conviction of crime involving moral turpitude, or for publicly advertising special ability to treat or cure diseases which, in the opinion of the Board, it is impossible to cure.

The law provides that those who secure license shall register in the county in which they began to practice or any other to which they may remove.

The law exempts from the necessity of examination all persons already entitled to practice in New Jersey, commissioned surgeons of the United States army, navy or marine hospital service, regularly licensed physicians or surgeons in actual consultation from other States or Territories, and regularly licensed physicians or surgeons actually called from other States or Territories to attend cases in New Jersey.

**Treatment of Stricture of the Urethra.**

Dr. W. L. Axford, of Chicago, says, in the *Medical Standard*, June, 1890:

The ordinary stricture of the urethra is a cicatricial band, the result of inflammation of the submucous areolar tissue, extending more or less completely around the canal and of greater or less calibre, according to age and rapidity of contraction. There are at present four different methods of treatment in good repute, viz.: Gradual dilatation, electrolysis (so-called), divulsion and urethrotomy, internal or external, according to the location of the stricture. Resorting to dilatation or electrolysis, the canal is gradually restored to its natural size by absorption of a portion of the stricture tissue each time the instrument is used. By divulsion or urethrotomy, the calibre of the urethra is at once restored, the wound is not allowed to close and absorption of the stricture follows. We can, on this basis, divide our four methods into two classes.

It has, for many years, been Dr. Axford's opinion that the second class of methods, particularly internal urethrotomy, gives the most satisfactory and permanent result. To this conclusion, based on clinical experience, he adds the weight of some philosophical inquiries which tend to strengthen the position taken. As above remarked, stricture of the urethra is a band of cicatricial tissue about the canal, which does eventually exactly what all such tissues do, contracts. This contraction becoming a source of annoyance, either by causing gleet if of large calibre, or by interfering with the free flow of urine if narrow, must be removed.

In the case of a stricture of the pendulous urethra, the result of a gonorrhœa, the connective tissue which underlies the urethral mucous membrane has, at certain points, become inflamed, leucocytes have infiltrated it, and in certain places, organization has taken place; the granulation tissue has developed into a fibrillated structure, the newly-formed capillaries have disappeared, and what was formerly fibrous tissue has been converted into a dense structure, the prominent characteristic of which is contraction. In order to get rid of this new tissue it must in some way be penetrated by leucocytes, softened and absorbed. In fact, the process of formation must be reversed, and absorption or resolution of the inflammatory mass must be secured in place of organiza-

tion. The usual explanation, that the pressure of the sound causes absorption, is simply absurd. We can easily understand how constant pressure on a mass of tissue might eventually, by shutting off a portion of its blood supply, cause its atrophy, or even disappearance; but to assume that the pressure of the sound or bougie for a few minutes twice per week causes absorption of a non-vascular mass like stricture is, Dr. Axford thinks, absurd. It might force the fibres closer together while *in situ*, but nothing more. Again, it is not necessary to leave the sound in for a few minutes. The stricture will disappear just as rapidly if the instrument be withdrawn as soon as its full size has passed the stricture. The explanation of this absorption which certainly does follow the use of the sound is this: The sound undoubtedly ruptures some of the fibres of the stricture and at the same time irritates or ruptures some of the small adjacent capillaries, and from them the leucocytes escape; the ruptured fibres of the stricture are now susceptible to their action and are invaded by them; a minute inflammatory process follows and a small portion of the stricture is absorbed. This process is repeated from time to time until eventually the entire mass is absorbed, or what is more probable, the major part of the band disappears. In support of these views, Dr. Axford quotes from the observations of Sir H. Thompson: At the first act of micturition after instrumentation, he says, the stream is increased in size, because of the mechanical effect of the sound; but after a few hours it is even smaller than before the operation. This he attributes to active congestion and spasm, but it seems plausible to think it is due to the escape of blood from small ruptured capillaries, or to an escape of leucocytes from irritated vessels and the invasion of the ruptured fibres of the stricture by these leucocytes, that is, to a small inflammation. After a few days the stricture is found permanently enlarged—resolution and absorption have occurred.

So far as electrolysis, so-called, is concerned, Dr. Axford has never been able to satisfy himself that any current, which could be used with safety in the urethra, could have any effect in so dense and unyielding material as stricture tissue. It is possible that the current may add to the effect of the sound a certain stimulating action and thus lead to a greater aggregation of leucocytes at the site of the stricture, perhaps in this



way being of some value. Therefore he has classed electrolysis with gradual dilatation as being simply a modification.

The results from dilatation vary. There are strictures so tough and resilient that the sound has no effect on them whatever. These are not necessarily those extremely hard strictures but those which combine elasticity and toughness. In these cases no fibres are ruptured and no field is opened for the work of the leucocytes. These can be cured by cutting. Otis says that in order to cure a stricture you must cut clear through it, and I believe that if you would cure a stricture by dilatation you must in time rupture every fibre of it, and herein lies the uncertainty as to permanent cure, which surely is the great objection to dilatation. Dr. Axford's experience leads him to believe that dilation cures only in recent strictures, and very recent at that; those in which organization is not yet complete and where all the capillaries have not yet disappeared from the cicatrix; here there would be a chance for leucocytes thoroughly to permeate the entire mass, and cure would be expected to follow.

Of the second class he does not favor division, because it is an unnecessarily rough procedure, and has no advantages over dilating urethrotomy. In this operation we have the best method, both practically and theoretically, before the profession. Practically it is safe, quickly done, and its after-treatment short; cure results, he believes, in every case where the stricture is thoroughly divided; that is, where every fibre is cut through. The dilatation before cutting permits you to put every fibre on the stretch and place it in the best condition to come in contact with the knife. If, after cutting, you screw up your instrument (the knife concealed) and find no resistance, you may be pretty sure that your stricture will be permanently cured. If resistance be encountered, or if with the acorn-pointed sound one can find any point giving the impression that division has not been perfect, he believes the stricture will invariably return. The rationale of this is very simple. The fibres being all divided, the entire mass is thus open to the action of the leucocytes, which escape in quantities from the cut vessels. The stricture has been placed in the best possible condition for them to do their work. In order that the two ends may not grow together, and thus again close up the field of work, the stricture is kept open from

time to time. Dr. Axford has always noticed one thing in the after-treatment, and that is this: Where there is a good, sharp inflammatory reaction, and the urethra is sore and cordy for a couple of weeks after the operation, that is, where plenty of leucocytes are present, that the result is pretty sure to be good.

### Diphtheria in Michigan.

Dr. Henry B. Baker, Secretary of the State Board of Health of Michigan, writes, under date of July 22, that the outbreak of dangerous disease which has prevailed in Otsego and Montmorency counties, Michigan, since last spring and which local physicians said was not diphtheria, permitting two of the corpses to be sent to Lapeer county where a case of diphtheria occurred in a person who viewed the remains, has been investigated by the State Board of Health, the investigation having been requested by a union meeting of the boards of health of three townships in those counties.

Prof. Vaughan, of the University of Michigan, a member of the State Board of Health, made the investigation. He has also made bacteriological examination of the membrane from the throats of two of the patients, and has found and propagated the micro-organisms which are believed to be peculiar to diphtheria. This species of micro-organism is known as Löffler's bacillus. Prof. Vaughan says: "The bacilli have been compared with the Löffler bacillus, which I had obtained in the laboratory of Dr. Koch at Berlin, and the identity of the two cannot be questioned." He reports the disease to be unmistakably diphtheria, as proved by symptoms, physical signs, throat paralysis, etc.; and the diagnosis is sustained by the bacteriological examination. It is now hoped and expected that the local authorities will take thorough measures to stamp out the disease.

### A Bad Kind of Quack.

The *Alabama Medical and Surgical Age*, June, 1890, in an editorial describes a specially offensive sort of quack with which the South seems to be afflicted. The *Age* says: The medical journals have devoted considerable space, first and last, to the discussion of "quack doctors" and exposing their many unprofessional deeds. From our stand-

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point one of the most contemptible professional wretches known to the medical profession in America is the quack—we care not what his attainments may be—who comes South and locates in one of our prosperous cities, ignores all professional dignity, and sets out to “clean up the field” by visiting the people from house to house and giving his name, and telling them of his wonderful skill as a healer of all diseases, and assuring them that his charges are much less than they have been accustomed to paying; and then, to further his ungentlemanly and unprofessional schemes, visits every negro at his house and work-shop, introducing himself as Dr. “So-and-So,” not forgetting to be specially polite, therefore addresses his friend in black as “Mr. and Mrs. Jones.” We know of a medical examining board in Alabama that is lamenting that they let a character of this description pass through their hands “by the skin of his teeth.” We believe in liberty and respect a physician who has energy and pluck to succeed in his chosen profession, but the man, claiming any degree of respectability, who would resort to such nefarious means to secure a practice is too contemptible for notice and is not worthy of recognition by the profession of America.

#### Injuries to the Penis in Coitus.

The *Medical Standard*, July, 1890, says that peculiarities of wounds after coitus in females have been much discussed, but those occurring in males have received but little attention although they throw some light on certain vexed questions as to the method of venereal infection. Reports of penis injuries are rare, albeit it is very probable many quickly-healing chancroids are not venereal but traumatic. Dr. A. A. Newsy, of Gorakhovetz, Russia, in *Vratch*, No. 48, 1889, who has recently discussed this subject, has been able to find only two cases in the literature, both reported by Americans. He says that Dr. Veazie has reported in the *New Orleans Medical and Surgical Journal*, 1884, a case of complete fracture of the penis and that Dr. F. Y. Davis has reported in the *Medical News*, 1885, a case where a gentleman suddenly detected his coachman copulating with a servant. Both made frantic efforts to escape, but were unable to separate. The man was over six feet high and heavy. The woman was small and did not weigh over ninety pounds. After several

attempts by bystanders to separate them by methods used with dogs, Dr. Davis was sent for, who found the man standing up with the woman in his arms; his penis locked in her vagina. Dr. Davis, after local applications of ice, chloroformed the woman and released the penis, which remained in a state of priapism for several hours. It was swollen, livid and sore for days.

Dr. Hulke, of London, has reported in the *Lancet*, Feb. 18, 1888, a case in which a deeply intoxicated thirty-four-year-old man, while copulating with his wife, sprained his penis, lacerating the left crus, which resulted in inflammation thereof and long-continued priapism. Dr. Newsy's case was that of a twenty-five-year-old man, who, while copulating with his wife, felt a sharp pain in the penis, which, on withdrawal, bled profusely from a laceration. Within half an hour the patient bled a cupful of blood despite cold applications. Dr. Newsy found a deep, widely-gaping, irregular laceration with everted tumefied edges, more than an inch long, running transversely across the penile posterior lower aspect about an inch from the prepuce, which was unusually long and tight and had but a very narrow orifice. The wound was washed out with a boric acid lotion, united by silk sutures and healed in six days by first intention. Dr. Newsy believed that during copulation the patient's long phymotic prepuce formed a terminal fold looking upward, which led to an extreme stretching of the skin on the lower surface of the organ, the tissues giving way at the point of maximal distention under violent pressure of the glands. Dr. Davis was of opinion that, in his case, a spasm of the sphincter at the vagina orifice had nipped the penis and prevented an outflow of blood. A similar condition seems to have occurred in the cases of Drs. Veazie and Hulke, and very probably in that of Dr. Newsy also. This spasm is a normal phenomenon of coitus in some lower animals and hence likely to reappear with females of bad heredity. Prostitutes are especially likely to have such sexual reversions to conditions normal among lower animals, since, as Dr. Pauline Tarnowsky has shown, degenerate types are frequent among them. Sphincter cunni spasms are hence likely to result in producing penile excoriations which may be mistaken for the results of venereal infection. Dr. H. N. Moyer, of Chicago, has observed a case in which livid penis excoriations from traumatism, during coitus,

were regarded as venereal ulcers. These excoriations, in all probability, are often starting points for venereal infection.

### Accident with Weigert's Apparatus.

The *Druggists' Circular*, July, 1890, reports the case of a woman, in New York, who came to her death through a singular accident, occurring during the use of Weigert's superheated air inhaler.

The apparatus employed consists of a metal cylinder mounted over an alcohol lamp. Within the cylinder is an inner cylinder, there being a space between the two. The bottom of the outer cylinder is perforated for the admission of heat and air, and from the top of the cylinder is a metal tube about two feet long and an inch in diameter, with a hard rubber mouth-piece for inhalation. In this tube is a thermometer to indicate the temperature of the air passing through.

The patient lighted the lamp, and when the thermometer indicated the temperature at which she was in the habit of inhaling the heated air she commenced inhaling. Almost immediately she felt an irritation of the throat and mouth. She thought that the tube had become clogged, and when she removed the mouth-piece she noticed a deposit of gray grains which she thought was dust. She cleaned it out and proceeded with the inhalation. In a few minutes she felt a burning sensation in her throat and chest and was attacked with nausea and vomiting. A physician was sent for, and he pronounced the patient to be suffering from mercurial poisoning. On examining the apparatus it was found that the bulb of the thermometer was broken, and the mercury which had become volatilized by the heat had been inhaled, causing acute inflammation of the respiratory tract and stomach.

Notwithstanding the utmost efforts of the physician the patient died the next day.

### Bichloride Mercury for Granular Lids.

The favorable reports which from time to time have appeared in regard to the value of strong solutions of bichloride of mercury in the treatment of granular lids have led to an extensive trial of this remedy in the eye wards of the Philadelphia Hospital. The results are reported by Dr. G. E. de Schwein-

itz, in the *University Medical Magazine*, July, 1890.

The method adopted was as follows: Every alternate day the everted lids are carefully touched with a solution of bichloride of mercury, 1-300 or 1-120, according to the size of the granulations, while three times a day the conjunctival cul de sac is irrigated with a warm solution of the same drug, 1-7000. No other medication is employed. The results were almost uniformly favorable. In no single instance did the disease become aggravated; in a few cases it apparently underwent no modification, while in the vast majority, after four or five applications of the character described, there was increased comfort, lessening in the size of the granulations, dissipation of the discharge, and not infrequently amelioration of pannus, if this was present. Perhaps the strongest testimony in favor of this application was that given by most of the patients themselves, all of the chronic cases having had all manner of local astringents applied to their everted lids. Their testimony is practically unanimous that this has given the greatest comfort. It is a painful application, and in sensitive patients the eyes may be cocaineized. In most of the instances, however, this precaution was not deemed necessary. These observations are based upon the experience of about thirty cases.

### Salol Ointment for Impetigo and Eczema.

The *Bulletin Medical*, June 4, 1890, says that Dr. Saalfeld has had good results with salol ointment in the treatment of impetigo contagiosa and eczema, accompanied by abundant suppuration. It was also efficacious in a case of parasitic syphilis. The formula used was as follows:

R Carbonate of potash . . . . .	1 part
Olive oil . . . . .	10 parts
Oxide of zinc . . . . .	15 "
Starch . . . . .	15 "
Salol . . . . .	5 "
Sulphur . . . . .	6 "
Lanolin . . . . .	100 "

Mix.

### Climatological Association.

The seventh meeting of the American Climatological Association will be held at Denver, Col., September 2-5, and it has been arranged that it shall be followed by a tour of Colorado under peculiarly favorable auspices. The party will be conducted by

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Dr. D. hermaph Ronen, v Maladies girl cons ing in he her such Thinking hernia, l examina pubes the of the about on of the th was perf low this the size which th noticed, legs were was by ing stro patient sixteen ance of and the the right size of sent size and wh testicle. the opp to pass the bla that he aminat patient ing wi of the in the In o tion of out of the sw theref which the tes comfo



Mr. T. P. Vaille, 114 South 4th street, Philadelphia, South-eastern Passenger Agent of the C. & N. W. Railway. Particulars in regard to rates may be obtained from Mr. Vaille, and the attendance of physicians interested in climatology is specially requested by the Association.

### A Case of Hermaphroditism.

Dr. Debout reported the following case of hermaphroditism to the Medical Society of Rouen, which is quoted in the *Journal des Maladies Cutanées*, May, 1890. A young girl consulted him, complaining of a swelling in her groin which occasionally caused her such pain as to unfit her for work. Thinking, of course, that the trouble was a hernia, Dr. Debout proceeded to make an examination. To his surprise he found the pubes thickly covered with hair, and in place of the clitoris, a small well-formed penis about one inch and a quarter in length, and of the thickness of a pen-holder. The gland was perfectly formed, but imperforate. Below this was a nearly circular opening, about the size of a quarter of a dollar, through which the patient passed urine. Dr. Debout noticed, at the same time, that the thighs and legs were very hairy. The face of the patient was by no means feminine, the features being strong, and covered with hair, which the patient sought to hide by shaving. Although sixteen years old, there had been no appearance of menstruation. The hips were flat, and there was no fulness of the breasts. In the right groin there was a tumor about the size of a nut, which had existed in its present size since the patient's thirteenth year, and which had every appearance of being a testicle. There was no similar swelling in the opposite groin. Dr. Debout attempted to pass a bougie through the opening into the bladder, but the patient was so sensitive that he was forced to desist. No rectal examination for the uterus was made. The patient was, however, clearly a male, suffering with hypospadias, arrested development of the penis, and having a testicle enclosed in the inguinal region.

In order to relieve the patient the application of a truss, such as used for hernia, was out of the question, since any pressure on the swelling caused great pain. Dr. Debout therefore constructed a truss, the pad of which had a concave surface which covered the testicle, and which was worn with great comfort and relief to the patient.

### To Preserve Ice.

The following method for preserving ice in a pitcher will not come amiss to those who need it for use all night or in the sick room. Fill the pitcher with ice and water and set it on the centre of a piece of paper; then gather the paper up together at the top and bring the ends tightly together, placing a strong rubber band around them to hold it close, so as to exclude the air. A pitcher of ice water treated in this manner has been known to stand over night with scarcely a perceptible melting of the ice.

### NEWS.

—It is reported again that Pasteur is to come to this country towards the close of this year or the beginning of next.

—Dr. Bushrod W. James, of Philadelphia, is recovering at Idaho Springs from an accident while on horseback riding up the Virginia Cañon.

—Dr. G. W. Groff, for thirty-six years a practicing physician at Landisville, Pa., died of a paralytic stroke July 18, at the age of 58 years.

—Dr. Hugo Engel, of Philadelphia, has been sued by a bank in this city for about six hundred dollars, due on a bank account overdrawn some time last May.

—It was reported from Cairo, July 23, that small-pox was ravaging the villages between Mansouray and Zagazig. The populations were said to be almost decimated.

—A birth of triplets was reported from Norristown, Pa., July 20. There were two boys and a girl. The infants were all well formed, and with the mother were quite hearty.

—At a meeting of the Berlin Municipal Council, June 12, it was decided that a convalescent home for lying-in women should be established at the expense of the city. A sum of \$35,000 was voted for the purpose.

—William C. Foulks, a dentist of Philadelphia, was held July 21 to answer charges of forgery and obtaining goods under false pretences from John Wanamaker. It has been asserted and denied that Dr. Foulks was insane.

—Bethlehem and West Bethlehem, Pa., were, on July 23, reported to have an epidemic that is puzzling the doctors. Some physicians thought it identical with break-bone fever. The cases were not numerous or grave.

—It is claimed that the possibility of inoculating cattle against Texas fever has been established by the experiments of the State Veterinarian of Missouri, though the certainty of preventing the destructive disease is not established.

—Dr. Jacob Roberts, a graduate of the University of Pennsylvania in 1862, died July 20, at his residence in Philadelphia. He was stricken with paralysis about eight weeks before, and had not left his home since that time. He was in his fifty-fourth year.

—In 1889, in the State of New York, says the report of the Railroad Commission, the number of employes killed while in the act of coupling and uncoupling cars was 27, and the number injured 364; in the previous year the killed were 26 and the injured 480.

—The National Women's Health Association of America was organized in Philadelphia July 23, with Caroline Dodson, M. D., as President. Its object is to bring the laity and the medical profession into closer relations by the discussion of health topics.

—About 350 Philadelphia physicians were registered at the Prothonotary's office in Camden before the new medical practice law went into effect—that is, noon of July 4. One hundred and seventy-five were registered on July 3, and four on the morning of the fourth.

—It is reported that on July 21, a Dr. Gustav P. Gehring, said to be of Philadelphia, and a Dr. Samuel R. Garwood, said to be of Pomona, N. J., endeavored to settle a discussion by a regular fist fight. The names of these persons are not in the directories of physicians in this office.

—Dr. Salmon, Chief of the Bureau of Animal Industry, Drs. W. H. Wray, A. D. Melorn and J. F. Ryder sailed July 26, for England, with authority from the Department of Agriculture to investigate charges that cattle imported into Great Britain from the United States are affected with contagious pleuro-pneumonia, and to make arrangements for the examination of cattle as they are landed from American ports.

—The Dominion Health Department has received a report from one of its physicians in regard to the leprosy on Anticosti Island. As a result of the inquiries he has made, he finds that some years ago several families removed to Anticosti from Caraquet, New Brunswick, where leprosy was found to prevail, and these are likely to be responsible

for the alleged existence of the disease on the island. The family affected consisted of fourteen persons. Prompt measures will be taken to segregate these persons.

—The officers of the Kensington Hospital for Women, in Philadelphia, are looking for a site for a new hospital. Before this can be bought it is necessary to raise \$20,000; and \$10,000 has been subscribed by a number of interested people. Dr. Howard Kelly, formerly surgeon to the Hospital, and now Professor of Gynecology at Johns Hopkins Hospital, has contributed \$1,000. The work at present is being carried on in two adjoining dwellings, which are not only too small, but also do not offer proper accommodations.

—From Ottawa, Ont., it was reported July 22, that a number of miraculous cures were taking place at the shrine of Ste. Anne De Beaupre in connection with a pilgrimage recently organized by Abbé Lesage. A young French-Canadian lady, who was weak and crippled, suddenly felt her strength return, while partaking of the communion, and threw away her crutches. A woman thirty-three years old who had been for two years paralyzed, was carried into the sanctuary, where, during the communion, she arose and walked through the church and seemed restored to perfect health.

#### OBITUARY.

##### JOHN D. GRISCOM, M. D.

On July 23, Dr. John D. Griscom, one of the oldest Fellows of the College of Physicians, of Philadelphia, died at his residence at Haverford College, near Philadelphia, at the advanced age of eighty-one years.

Dr. Griscom was the son of William Griscom. He was descended from a long line of Griscoms, and it is said that the founder of the family came to this country in 1660, and was one of the sturdy settlers who left their impress on the succeeding generations.

He was born in Philadelphia March 15, 1809. He was educated at the University of Pennsylvania. He was one of the oldest living Fellows of the College of Physicians in Philadelphia, to which he was elected in 1842, and for many years was chairman of the Obstetrical Committee. He was married in 1839 to Margaret W. Acton, of Salem, N. J., who survives him. He also leaves two sons.